L 8 2 71



COUNTY COUNCIL OF THE WEST RIDING OF YORKSHIRE

ANNUAL REPORTS

of the

COUNTY MEDICAL OFFICER

and the

PRINCIPAL SCHOOL MEDICAL OFFICER

for the Year

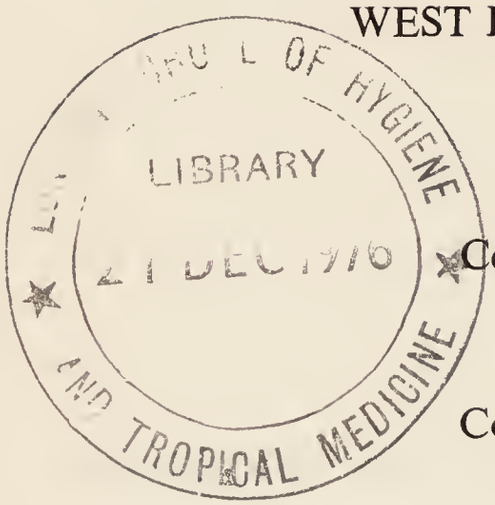
1971

RONALD W. ELLIOTT, C.B.E., M.D., M.SC., F.F.C.M., D.P.H.

HEALTH DEPARTMENT, WOOD STREET, WAKEFIELD

TELEPHONE 75234

83024



WEST RIDING HEALTH COMMITTEE

(as at 31.12.71)

CHAIRMAN

County Alderman W. Hudson

VICE-CHAIRMAN

County Councillor C. A. Smith

COUNTY ALDERMEN

Atkinson, D. W.
Baynham, T., O.B.E.
Cutts, W.
Fitzpatrick, Mrs. L. I., C.B.E.
Hardaker, Mrs. L., M.B.E.
Ives, Major T. H., C.B.E., D.L.
(*Chairman of the County Council*)
Morris, W. A.
Newsam, A.
Prendergast, J.
Smith, Mrs. E. E., O.B.E.
Smith, Mrs. J., C.B.E.
(*Vice-Chairman of the County Council*)
Sutcliffe, H.

COUNTY COUNCILLORS

Boot, Mrs. B. A.
Burton, Major P. W., M.C.
Bushby, M.
Cawdry, Mrs. K. M.
Crawford, Mrs. J. G.
Crompton, Mrs. E. M.
Culpan, J.
Dando, T.
Dawson, F.
Drake, S. H.
Duggan, T. M.
Egan, R.
Etchells, G. S.
Farrer, Dr. J. A.
Fowler, Mrs. E.
Goldthorp, S. D.
Goodwin, R.
Hardwick, Mrs. D.
Hepworth, S.
Illingsworth, S., B.E.M.
Jackson, Mrs. B. H.
Kenningham, Mrs. D.
Milton, H.
Newsome, Mrs. B.
Pickard, Dr. J. W.
Pickersgill, A.
Rhodes, H.
Roebuck, T.
Shaw, H.
Smith, Mrs. Joan
Stevens, H.
Stockhill, E.
Turner, J. R. B.
Upperdine, M.
Waterhouse, A.
Watson, Mrs. G. M.

WEST RIDING EDUCATION COMMITTEE

(as at 31.12.71)

CHAIRMAN

County Alderman Mrs. L. I. Fitzpatrick, C.B.E.

VICE-CHAIRMAN

County Alderman C. T. Broughton

Representative Members:—

COUNTY ALDERMEN

Batty, T.
(*Chairman of the Finance Committee*)
Baynham, T., O.B.E.
Boland, C. W.
Dews, C.
Hardaker, Mrs. L., M.B.E.
Hudson, W.
Ives, Major T. H., C.B.E., D.L.
(*Chairman of the County Council*)
Miles, H.
Nicholson, G. H.
Smith, Mrs. J., C.B.E.
(*Vice-Chairman of the County Council*)
Sykes, Mrs. E. M.
Yorke, J.

COUNTY COUNCILLORS

Aspin, T. H.
Bean, Mrs. M. V.
Beever, L.
Bloomer, I. R.
Blythe, C. P.
Bott, G. N.
Cooper, F.
Cross, Miss D. L., B.A., B.SC. (ECON.), L.ES.L.
Doyle, P.
Free, N.
Jackson, Mrs. Y. B.
Jones, C.
Lawton, J. A., M.A., B.SC., M.ED.
Lea, R.
Mann, C.
Moore, J. R.
Moxon, H. C.
Pettit, Mrs. P. V.
Price, J. H.
Ripley, A. P.
Shaw, H.
Spurr, J.
Thompson, D.
Watson, Mrs. G. M.
Wilson, J.

Added Members:—

Clayton, W., O.B.E.
Haigh, R. H., O.B.E.
Martin, Mrs. M., LL.B.
Pollard, A.
Roberts, Mrs. E.
Robson, Prof. H. N., M.B., CH.B., F.R.C.P., F.R.A.C.P.
Ross-Gardner, Mrs. E.
Smith, H.
Warren, R. A. D.
(1 vacancy)

Table of Contents

	Page
Introduction	5—11
Special Reviews	13—63
Survey into the Work of the Health Visitor, 1970	14
Management Structure of the County Nursing Services	20
Distribution of Welfare and Other Foods	25
A Pyramidal Structure for Health Education in Schools	46
Pollution of the Environment	56
The Dental Health of Mongols in Day Special Schools and Training Centres	62
PART I	
Vital Statistics	66—71
Epidemiology	72—78
Venereal and Sexually Transmissible Diseases	79—81
Research	82—84
PART II	
Co-operation in the Health Service	86—92
Divisional Administration	93
PART III	
Local Health Services	95—116
Care of Mothers and Young Children	96
Midwifery	99
Health Visiting	101
Home Nursing	102
Ambulance Service	104
Prevention of Illnesss—Care and After-Care	110—116
Health Education	110
Renal Dialysis	115
PART IV	
Environmental Hygiene	117—123
Food and Drugs Act, 1955	118
Sanitary Circumstances	121
PART V	
Miscellaneous Services	125—128
PART VI	
The Health of the School Child	129—147
The School Dental Service—Report of Principal School Dental Officer	144—147
Orthodontics	147
Appendices	
A Tables	149—227
B Report of County Analyst	228—230
C Report of School Medical Officer to the Keighley Excepted District	231—250
D Staff of the Department	251—258

INTRODUCTION

THE RUN UP TO 1974

An advantage in allowing the introduction to the Annual Report to refer to matters outside the calendar year under review is that it enables current affairs to be related to the year in question.

The White Paper

The recently issued White Paper entitled *National Health Service Reorganisation; England* dated August, 1972, makes our understanding of the Government's Consultative Document issued in May, 1971, a little more complete. Obviously the details of reorganisation must still await further studies of the Management Study Steering Committee Report* and from the Collaboration Working Party but the following extracts dealing with the general principles of reorganisation should be noted as firm directions in which it is hoped the service will proceed. On reorganisation, the White Paper says:

"It is about administration, not about treatment and care. But the purpose behind the changes proposed is a better, more sensitive, service to the public."

"Everyone is aware of gaps in our health services. Even for acute illness, where we provide at least as good a service for our whole population as any country in the world, there are some respects in which we achieve less than we could. On the non-acute side the services for the elderly, for the disabled, and for the mentally ill and the mentally handicapped have failed to attract the attention and indeed the resources which they need."

" . . . domiciliary and community services are under-developed."

" . . . there must be more emphasis on prevention—or at least on early detection and treatment."

"For the imbalances and gaps Governments must take their share of the responsibility. Resources were and still are stretched. The acute services had a legitimate priority. But the shortcomings were not rational. They did not result from a calculation as to the best way to deploy scarce resources. They just happened."

"Why did they just happen? Because it has never been the responsibility—nor has it been within the power—of any single named authority to provide for the population of a given area of a comprehensible size the best health service that the money and skills available can provide."

"There are very strong arguments for bringing health and social services under a single administration. This could be accomplished by putting the NHS within local government. But, for reasons accepted and fully explained

*This Report, *Management Arrangements for the Reorganised National Health Service* has now been published.

by both the previous and the present Government, that is not attainable, at least in the foreseeable future."

"The National Health Service is one of the largest civilian organisations in the world."

" . . . never enough money—and never likely to be—for everything that ideally requires to be done."

"Real needs must be identified . . . management and drive must be continually applied."

"The NHS administering authorities will be entirely new bodies covering the whole field of health care, domiciliary and institutional. Their membership and administrative structure will be such that they are not dominated by people whose main interests lie in one or other service."

"There will be no question of the community health services swallowing up the hospitals, or, a more common suspicion, vice versa."

" . . . the health authorities will have comprehensive health education powers . . . local authorities will have complementary powers."

"Environmental health will also continue to be a function of local government . . . responsibilities will be vested in the district local authorities."

"All this has not been done just to get administrative tidiness. Unification offers solid advantages to the individual and the family, because their needs for health and social services are not divided into separate compartments."

The above extracts have been chosen intentionally to illustrate the problems and dilemmas involved in the preparation for 1974. Several senior members of the West Riding Health Department have been directly involved in various experiments and local government studies in connection with the reorganisation plans. Both the Management Study Group and the Collaboration Working Party referred to in the Consultative Document have had officers from the Health Department participating and the County Councils Association during this difficult period have also been advised from the Health Department. The Hunter Working Party on Medical Administration, which has recently reported, also had on its membership a senior officer from this department. At the time of writing the Principal Regional Officers of the Department of Health and Social Security have inaugurated liaison committees at both regional and area level whose functions will be to prepare the ground for the new shadow health authorities to be formulated next year. A considerable number of senior members of the Department are already involved in this work and no doubt as it develops practically every member of the department will need to play a larger or smaller part in the deliberations and fact findings.

The Special Position of the West Riding

It will be clear from the extracts from the White Paper quoted above that it is the intention to integrate all three branches of the present health services and to administer them as one. Nevertheless, it would appear that as far as the general practitioner services and the hospital services are concerned, in most parts of the country, there can be a natural drift of the existing administrative machinery carrying with it its accumulated local experience and expertise to add to the sum total of knowledge of the new service. As far as the preventive services are concerned the position is not quite so clear. Already they have shed some responsibilities to social service and education departments, which will remain with local government anyway, and still others will be left behind with the new local authority districts, particularly environmental work. Added to this upheaval the remaining health department staff will need to adapt themselves to an essentially new role. The change may not be quite so acute in county health departments outside the metropolitan areas, or for the county borough health departments within the metropolitan areas, but the West Riding appears however to have inherited the worst of all worlds in that it is utterly and completely shattered into 14 different parts and in this respect is probably therefore unique. This situation has already been pointed out strongly to the new Health Services Staff Advisory Committee/Commission, who may well find it a particularly difficult problem. More important still perhaps is the dividing up of some centrally controlled services which do not readily lend themselves to being carved up. Health centre developments, ambulance services and nursing administrative structures immediately come to mind in this context and the disposal of records alone will be a massive task. Special efforts will need to be made to retain what is best of these services but it will not be an easy task. It is appreciated in general terms by all employees in the Health Department that the ultimate aim of the reorganisation is to be supported to the full. It would however be unnatural not to expect a certain amount of uncertainty and anxiety amongst members of the staff. It is a little ironical when one realises that local government itself had its origins in the health needs of the public, (I think it is true to say that the West Riding was the first county to appoint a County Medical Officer), that local government in general should lose its health services in 1974 and that the West Riding Health Department in particular should disappear without any obvious successor, but in order to record its existence steps have already been taken for a short history of the West Riding Health Department over the last 85 years or so to be produced.

The Changing Pattern of Work

The White Paper obviously anticipates a new pattern of work for the preventive services. It is realised that in the interest of good management the ascertainment of health needs will be the prime concern of some of our successors in order that valuable resources can be economically and effectively applied. I can see no other experienced people immediately and readily at hand with the necessary expertise to further these aims than those at present working in community medicine. This has been realised for some little time now and the Hunter Working Party Report and many others emphasise this fact. Some examples, from a single year's

activities, of the changing pattern of work and which is gradually leading up to this new situation can be seen in this current Annual Report and a selection from them will illustrate the point. As mentioned in my last Annual Report there has been a rapid development of child assessment work by health visitors and medical officers. The scheme was fully described last year. It has been accepted by the staff as a very valuable contribution to their preventive armamentaria. The following illustrates its effect:

In 1965, 17 cases of congenital dislocation of the hip came to our notice. It was in this year however that routine testing started with the result that until 1970 a steady 50 cases or so were discovered each year. As a result of our developmental assessment scheme the figure rose in 1971 to 142 cases, largely picked up at the three months' routine assessment. This result emphasises the value of assessment and also the difficulty experienced even by consultants in making a firm diagnosis soon after birth. Another example from this report of the changing pattern of work is the discovery since the introduction of the Guthrie test for phenylketonuria of six new confirmed cases in 1971, a far greater number than would otherwise have come our way.

Dr. Harvey's essay on Health Education reproduced in this Report is another example of a new look at this difficult subject which is worthy of consideration and represents a serious attempt to meet the challenge of the future.

The new Mayston Nursing Structure reported on last year has now been in operation for 12 months, and although this is not long enough to give a full assessment of its value, it does, even on a preliminary assessment, show an advancement on the previous working arrangements. It will be seen from the Report how our liaison with hospitals has improved as has also our 24 hour nursing service and our specialised attention to such subjects as renal dialysis at home and the care of many other handicapped people discharged from hospital. All this is believed to be the direct result of the introduction of first line managers.

The vision testing of three year olds is a distinct advance on previous practice.

The rapid advance in our plans for the growing problem of family planning is being geared to modern needs.

Screening tests for the elderly and the development of well-women clinics are proceeding in a direction which will assist the general practitioner and hospital services as will also the introduction of radio telephones for midwives.

It will be seen that the activities of a modern health department are not rigid and static and that their continued movements forward must be encouraged within the new health service.

Social Services

After a year's experience of the new type of health and social service departments it is interesting to note that at least in this first year there has been very little change in the field work of the health visitor. One might perhaps have

expected some change to have occurred—although it is too early to speculate—and that it has not, could indicate the need for specialised social work in the health services as against the modern trend for generic social workers. This same problem needs to be looked at objectively, in due course, in connection with medical social workers in hospital and with mental health social workers, both being groups of workers who have hitherto been closely associated with doctors in team activities.

During 1971 with the agreement of the Director of Social Services permanent working parties as between the health and social service departments have been set up, one to deal with the problems of children and the other to deal with the problems of adults. It has been recognised by both the Director and myself that some such mechanism must be effective if joint working relationships are to be maintained. These working parties appear to be serving their purpose and although they cannot continue in the same form after 1974, because of the reasons I have already given, perhaps they may set some sort of pattern for future activities as between the new health and new local authorities. At least some experience will have been gained by some people in an essential collaborating role.

Research

It is not often realised how much research and enquiry is carried out in a health department of a local authority, but since this is likely to be one of the important functions of community medicine for the future, if the pattern indicated by the White Paper and the Hunter Working Party is followed, it may be of interest to list below some of the enquiries in which the department is currently engaged:

The continued investigation into childhood cancer.
A survey of mongols in West Riding training centres.
Measles vaccination trials.
Taking part in a survey of lung cancer in chrome workers.
An investigation into the dental condition of mongols.
An investigation into the dental health of children in an area of the county which has been subject to fluoridation of water supplies for three years.
An assessment of the size of the problem of handicapped people living alone, later extended to an investigation of all handicapped people.
Taking part in a national surveillance of congenital rubella defects.
An investigation of lead in water supplies and in various industrial emissions.
A projected pilot survey into the incidence of hypothyroidism and associated mental handicap.

All these subjects have a very high preventive medical connotation.

Vital Statistics

For the County as a whole the important vital statistics compared very favourably with those for England and Wales. The advantage of a large county however

is that one is able to analyse these statistics by local authority district boundaries in an attempt to look at the more detailed implications of the varying rates within the overall pattern. The interesting thing to note is that if one does this one finds that although the pattern as a whole is good those districts which fall below the average seem to be concentrated in the coal mining areas and in the areas which have a large proportion of immigrants. This certainly is a challenge to the future community physician.

Ambulance Service

Following the Millar report some few years ago there has been a consistent attempt to improve the effectiveness of the ambulance service, its control, and the status of its personnel. It will be seen from the ambulance section of the report that various measures have been taken to these ends. It has now been agreed for instance that a new training centre for ambulance personnel for this region will be established in Keighley and the project is under way. This will replace a smaller but successful scheme in Cleckheaton being carried on in most unsatisfactory premises. Gradually too the control of the ambulance service is being centralised in the new control centre at Birkenshaw and this is proving very effective. The whole scheme is not yet complete because we have been in difficulties through not knowing what the future pattern of the service will be. Fortunately research has shown that there is a pattern of ambulance journeys which will allow the service to be split quite easily between health regions 2 and 3. It is however hoped that the centralisation of control within each region and which is developing satisfactorily will not be undone and that in these metropolitan areas centralisation will be allowed to continue, otherwise the whole successful effort of many years could well be nullified. I have been very impressed with the way in which the hospitals throughout the county have reacted to our request for a short period of training for our ambulancemen, within the hospital. The hospitals have gone to a great deal of trouble to help us in this way and already 120 men have been so trained and another 185 are booked to attend. I would like to thank the hospitals for their considerable help and enthusiasm. Another interesting medical aspect of the ambulance service is the result of a local enquiry which is reproduced in this Report on the transport of poisoning cases to hospital. It transpires that out of 833 such cases transported during 1971, 563 of them were drug poisoning and a further 19 a mixture of drug and alcohol poisoning, a very formidable proportion. Only 42 were due to household poisons and as few as six due to gas poisoning. This latter is most interesting in the light of previous experience. An interesting experiment jointly with Airedale District General Hospital in the use of a hospital based and staffed emergency vehicle has also been introduced.

These interesting and stimulating developments in the ambulance service have unfortunately been marred during the last two years by intermittent industrial action on the part of the men concerned. A discussion on the merits and demerits of this is not the business of an Annual Report except to say that one has always considered an ambulance service to be part of a humane medical service which does not naturally lend itself to militant action. One feels therefore

that the spirit of the Millar report which seeks to improve the status and standard of this para-medical service could well be lost if public goodwill is forfeited, and some of the events of the recent industrial action have not been to the credit of the service as a whole.

Summing Up

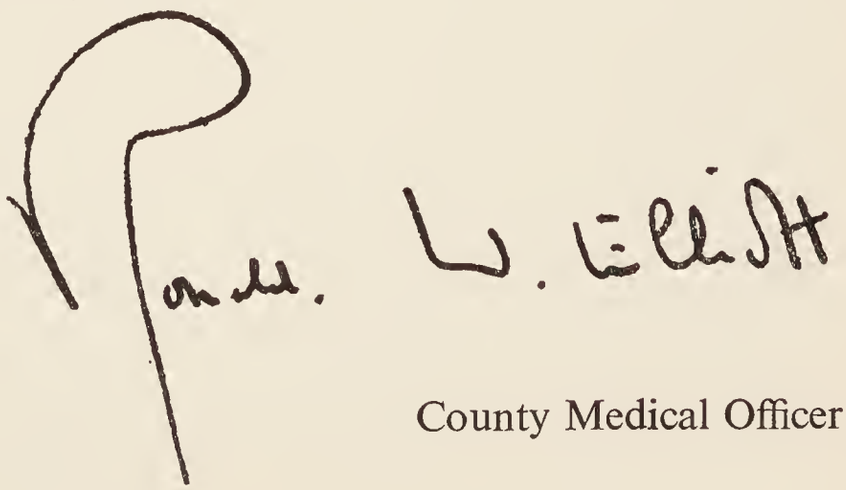
I hope that this brief introduction to my Annual Report will indicate that the health department realises that it is in for profound changes, probably more so than any other branch of the service, and that it is ready for it and has made some attempt to prepare for it.

It will be fairly obvious from what appears above that all members of the staff will be considerably affected by the extra work which will fall to be done in preparation for the 1974 reorganisation. I would like to thank them all for their past efforts and for the coming exertions which I know they will shoulder readily.

There have been a number of losses of senior medical and administrative staff to the department during 1971/72. Dr. M. Hunter retired from the post of Divisional Medical Officer at Skipton after having been with the divisional scheme since its inception. Dr. P. M. Sammon, Divisional Medical Officer at Huddersfield left to take up a similar post with Lancashire County Council, and Dr. J. T. Clow, Divisional Medical Officer at Rotherham, joined the medical administrative staff at the Sheffield Regional Hospital Board. We wish them every happiness and success in their new sphere of life.

Dr. J. A. Burgess, who held the post of Consultant Venereologist to the County from 1938 and Consultant to the Leeds Regional Hospital Board from 1948, retired after developing an unusually active interest in liaison between the two services. He has been an extremely conscientious and valuable member of the staff in this very difficult field of preventive medicine and we wish him a long and happy retirement.

There have been two sad losses to the staff during the past 12 months. Mr. Gilbert Richardson, the Chief Administrative Officer to the department who played an invaluable part in the organisation of our successful liaison with general practitioners, died in April after a short illness as did Dr. J. Battersby, the Divisional Medical Officer for Shipley. They both had long and honourable service with us and will be missed very much.



Health Department,
Wood Street,
Wakefield.

County Medical Officer

September, 1972

SPECIAL REVIEWS

Survey into the Work of the Health Visitor, 1970

Management Structure of the County Nursing Services

Distribution of Welfare and Other Foods

A Pyramidal Structure for Health Education in Schools

Pollution of the Environment

The Dental Health of Mongols in Day Special Schools and Training Centres

SURVEY INTO THE WORK OF THE HEALTH VISITOR, 1970

Marjorie G. Atkinson, Chief Nursing Officer

A survey into the work of the county health visiting service was undertaken during six weeks in 1970 to review the overall volume of work, detect any new trends arising from working in general practice situations and see what work could be delegated by health visitors to assistants to health visitors and others.

The survey took place during the last week of the Easter holidays and the first five weeks of the summer term. A scatter of the 19 health divisions was planned for each of the three fortnights involved.

All work time for each fortnight was coded according to activity, and results tabulated on percentage of total time. A three-day pilot survey checked the code sheet.

Briefing meetings gave all members of staff the opportunity to elucidate coding intentions prior to the survey.

Staff involved:

Health Visitors	241	whole-time and
	23	part-time
	264	
Assistants to Health Visitors	51	whole-time and
	53	part-time
	104	

The average length of the full time health visitor's working week was 38 hours 41 minutes, and the length of the assistant's week 37 hours 59 minutes. (Tables 1—5)

Table 1
General Outline of Work Undertaken
Percentage of Total Time

	Health Visitors	Assistants to Health Visitors
Clerical work	25·1	19·5
Effective home visits	24·1	13·2
Clinic work	17·4	23·1
Travelling	13·6	13·1
Consultations	6·2	2·2
School work actually with children ...	5·8	22·2
Health education	2·1	0·2
Ineffective visits	1·1	0·8
Miscellaneous	4·6	5·7
	100·0	100·0

Table 2

Effective Home Visits

Health Visitors	*Percentage of Total Time*
Expectant and nursing mothers	0·5
0-5 years, first visits	4·3
0-5 years, follow-up visits	7·8
Children on observation register	0·4
Hearing tests	0·5
Immunisations	0·1
Nurseries and Child Minders Regulations	0·2
Tuberculosis and infectious disease follow-up...	0·6
Handicapped children over 5 years	0·2
Follow-up of school children	0·8
Supportive visits, mental illness...	0·3
Mental handicap...	0·1
Hospital admissions and discharges	0·6
Problem families	0·9
Supportive visits, including rent guarantees	0·4
Housing reports	0·5
Home help visits	2·8
Chiropody	0·4
Meals on wheels	0·1
Geriatric visits, other than above	2·6
	24·1

Assistants to Health Visitors	
Visits to children under 5 years	1·6
Other home visits..	11·6
	13·2

Table 3
Clinic Work

Sessions	*Percentage of Total Time*	
	Health Visitors	Assistants
Child health	10·6	12·7
Immunisation	1·0	0·5
Hearing screening	2·9	2·6
Ante and postnatal	0·6	0·8
Mothercraft and relaxation	0·7	—
Cervical cytology	0·2	2·6
Geriatric screening	0·1	—
Specialist (including hospital liaison) ...	1·1	2·5
Minor ailment	0·1	0·5
Adult medical	0·1	0·5
Well-women screening	—	0·4
	17·4	23·1

Table 4
All School Work

Activity	*Percentage of Total Time*	
	Health Visitors	Assistants
Home follow-up...	1·0	1·0
Hygiene inspection	1·7	6·3
Hygiene and foot inspection	0·3	1·1
Scabies infestation inspection	0·1	0·1
Medical examination	1·3	5·6
Skin testing and B.C.G.	—	0·4
Immunisation	0·2	0·7
Vision testing	1·1	3·3
Colour vision testing	0·2	0·5
Audiometric testing	0·9	4·2
Health education	0·6	0·1
Consultations	0·7	0·6
Clerical work	1·0	3·0
	9·1	26·9

Table 5
Clerical Work

Percentage of Total Time

	Health Visitors	Assistants
Related to mothers and children ...	7·4	1·1
„ „ other visits	2·3	2·9
„ „ clinic work	3·2	4·3
„ „ school work	1·0	3·0
„ „ consultations	0·3	0·1
Miscellaneous	10·9	8·1
	25·1	19·5

General Comments:

The percentage of qualified health visitors' time spent in *effective home visits* was low at 24·1 and, in the comments from staff relating to their work, the majority felt that insufficient time was available for this purpose. It was considered that children under five years, the elderly and the handicapped members of the community particularly needed more visiting at home.

The 13·2 per cent. time spent by assistants to health visitors in home visits was mainly to elderly people in relation to provision and supervision of home helps. This service was in process of passing to home help organisers at the time of the survey. The small proportion of visits to children under five years was in relation to immunisation defaulter visits.

The opportunity has been taken to estimate the probable total number of visits paid during the course of the year, since these are no longer recorded annually. The decreasing trend in home visiting of the last decade is still evident and it would appear that each qualified health visitor pays approximately 45 home visits weekly. Bearing in mind the need for many more clinic sessions, this is a reasonable average.

Clerical work time was high at 25·1 per cent. and 19·5 per cent. Surveys in Hertfordshire (1970)[1] and in Bolton (1967)[2] found 19·8 per cent. and 20 per cent. respectively. Action has been taken in various ways to reduce this level of administrative time, although it is appreciated that some clerical work will necessarily remain with the health visitors.

Clinic work patterns were broadly satisfactory but, with the introduction of developmental assessments very shortly after the survey, the picture of traditional child welfare is changing considerably.

Travelling times, at 13·6 per cent. and 13·1 per cent. were lower than times found in the West Riding (1968),[3] 17·5 per cent. and 16·9 per cent. respectively, and lower also than the travelling time in Bolton (1967) at 24 per cent. Hertfordshire (1970) found travelling occupied 11·7 per cent. of health visiting time.

Consultations included discussions with general practitioners, patients at general practitioners' surgeries, local health authority colleagues, social work colleagues and school consultations.

School Work in Table 1 is time actually spent with children and is enlarged to show all work in relation to schools in Table 4. These figures show clearly the role of assistants to health visitors in school programmes, and also the involvement of qualified health visiting staff at the commencement of a new term.

The fact that the survey times included part holiday and part commencement of term, and of the summer term at that, is reflected in the very small amount of *health education* undertaken during these weeks.

The miscellaneous figure includes such items as Mothers' Clubs, preparation for visiting students, visits that do not fit into coding elsewhere, and clinic work also that does not fit described activities. These figures of 4·6 per cent. and 5·7 per cent. are acceptable.

The research into health visitors' work undertaken in 1969 by the Greater London Research Department of Planning and Transportation[4] found that health visitors spent about $3\frac{1}{4}$ hours daily in face-to-face consultation with members of the public. The West Riding survey suggested a rather higher figure since 50·4 per cent. total time was involved with face-to face contact with clients. The West Riding health visitor's day was $7\frac{3}{4}$ hours, so that face-to-face activities would be near $3\frac{3}{4}$ hours.

It will be noted that figures given relate to the whole county and are not separately given for staff attached and unattached to general practices.

The differences were surprisingly small and, indeed, with some staff wholly attached, others attached to practices together with areas, and some not yet attached at all, the numbers involved in each of the three groups were also small. In the comments made by qualified health visitors, however, the sense of being more fully involved with the whole family came out quite clearly from attached staff.

The survey showed no demonstrably new trends arising from attachment to general practice. Increased geriatric visiting has taken place wherever good relationships exist between general practitioners and local authority staff, and not only where full attachment arrangements are in force. Greater understanding can well develop from using the same building, and the benefits originally associated with full attachment may then develop to some degree.

The survey highlighted the need for increased clerical help for staff, and indicated that assistants to health visitors were, in the main, giving appropriate help to the qualified health visitors.

In discussion sessions following the survey, health visitors showed keen interest in the findings and were already considering ways of preparing for clerical assistance by rationalisation of filing systems.

It would appear that a very small volume of work has gone from field health visitors as a result of the setting up of the Social Services Department. The undertaking of registration and investigation of play groups, child minders and private day nurseries by social workers has relieved divisional nursing officers and would be the largest single item.

Since the survey, new work has been introduced including a direct *family planning service* in some areas. *Developmental assessments of children under five years* has become county-wide (the county programme was described in the 1970 Report). Whilst developmental tests replace some aspects of former visits, the need to visit each child in her case-load of 300—600 children at specific ages will call for careful planning on the part of each health visitor as the cumulative effect of the scheme develops over four years. *Vision testing of three-year-olds* can prove highly valuable where defects are discovered several years earlier than formerly. The tests are time consuming, especially until the staff are really practised in the new skill. *Rubella vaccination* of schoolgirls has proceeded steadily and this scheme will obviously extend very shortly to older women at risk. *Screening sessions for the elderly*, and for *well-women*, are developing and call for health visiting help.

The promotion of good health by education of each generation of mothers, by careful infant screening, and by immunisation procedures is of immense national and individual value and the work of health visitors in these fields must be encouraged and developed as new needs arise even if such encouragement delays the use of qualified health visitors in the hospital field.

Good school health care, and health care of the elderly and handicapped also take place outside hospital and will need consideration in the integrated service of 1974. Certainly the West Riding survey and new developments since that time indicate wide variety and volume of work requiring health visiting skills, and willingness on the part of health visitors and their assistants to respond to new needs.

References:

1. Allen, W. H., King, V.M., Abbott, G. M.
 "Domiciliary Nursing Services in Hertfordshire."
 Medical Officer, 1970, *124*, 217 and 223.
2. Gallaher, E., Howe, J. E., McNeil, A. W., Richardson, E. M., Ross, A. I.
 "A Study of Health Visiting and District Nursing in Bolton."
 Medical Officer, 1970, *123*, 161.
3. Clow, J. T.
 "Attachment of Health Visitors to General Practice."
 Medical Officer, 1968, *119*, 173.
4. Morris, T.
 "The Work of Health Visitors in London."
 Greater London Research Department of Planning and Transportation Research Report No. 12, 1971.

MANAGEMENT STRUCTURE OF THE COUNTY NURSING SERVICES

Marjorie G. Atkinson, Chief Nursing Officer

In the Report for 1970, reference was made to the *Report on the Management Structure in the Local Authority Nursing Services*—the Mayston Report. These comments relate, in the main, to the changes resulting from the implementation of the recommendations of the Report.

Structures Compared

	Pre 1971	*Present*
Headquarters	Chief Nursing Officer	Chief Nursing Officer
	Deputy Nursing Officer	2 Principal Nursing Officers (geographical)
	Health Education Officer—(not in Nursing Section)	1 Principal Nursing Officer (Health Education)
	2 Non-medical Supervisors of Midwives	2 Non-medical Supervisors of Midwives
Divisional	18 Divisional Nursing Officers co-ordinating all nursing services	18 Divisional Nursing Officers (Area Nursing Officers in Mayston terminology)
		24 Nursing Officers, Health Visiting
		18 Nursing Officers, Home Nursing
		10 Nursing Officers, Midwifery
	Field Staff	Field Staff

It will be seen that the major change was the appointment of nursing officers in the three separate disciplines that combine to form the nursing service. These nursing officers were chosen partly for management ability and partly because they were well trained and experienced in one field of community nursing and were therefore able to command respect from the groups whose work they co-ordinate. Field staff in the community services are recognised by the Mayston Committee as needing to take decisions and decide priorities in the course of their work, and the appointment of nursing officers is in no way intended to interfere with this normal professional expertise.

It is the nursing officers who draw on the experience and knowledge of their colleagues, discover new needs, interpret new policies and techniques, and report on the effect of new procedures, in the promotion of better patient care.

Field staff have a channel of communication more easily available to them—a nursing officer particularly experienced in each field of care.

Orientation of new staff is possible in greater depth than formerly and is much appreciated. Encouragement of established general practitioner/local authority attachments is written into their job description.

The administrative part of the nursing officer's work includes day-to-day coverage of the service, assistance with record keeping, her own report writing, checking of equipment, uniform and acting up for her own service in the absence of the divisional nursing officer.

The personnel function of assisting each of her colleagues to reach her full potential may well develop more slowly, but will be of increasing importance as the service to which we belong becomes one vast organisation in 1974.

At the time of writing few nursing officers have been in post much more than a year, but there are encouraging developments stemming, at least partly, from this first line management structure.

In the home nursing service, the county night-nursing service has been extended considerably and is now using 54 qualified nurses and 38 women with nursing experience instead of a total of 35 a year ago. The service remains temporary to assist the terminally ill, patients who expect imminent admission to hospital and relatives who need relief from the long strain of disturbed nights.

Training for renal dialysis in the home was more confidently undertaken with the home nursing officer taking the special instruction too. Whilst this is undertaken only exceptionally by local authority nurses, the added knowledge gives depth to the support that can be offered to the many relatives who undertake this very arduous programme for patients at home.

In the health visiting service, more can now be done to help assistants to health visitors understand more fully their day-to-day work, and to help newly appointed qualified staff to undertake effective health education. The scheme of developmental assessments called for initial preparation of staff to commence the tests at different ages. It is the nursing officers who are helpful in standardising the efficiency of the tests by knowing the tests very well themselves, and by ensuring the use of exact equipment throughout the divisions.

The midwifery nursing officers are fewer in number, and are not all in post. Useful work has been done in reviewing the syllabus for mothercraft teaching, and in assistance with a survey into midwifery work carried out recently.

In all services liaison with the hospital service is developing, sometimes in relation to specialties—building on a long county history in this sphere—and sometimes in relation to practical arrangements relating to admissions, discharges and general follow-up.

In all services, too, the nursing officers are beginning to be involved with student nurses, as the General Nursing Council Syllabus of 1969 takes effect. The first students have now spent six weeks in the community, and in many other areas programmes are being prepared for further groups.

The nursing officers are responsible to the divisional nursing officer. The County Council appointed the first divisional nursing officer in 1958, and from then until 1971 these officers have been responsible for the day-to-day work (now passed to their nursing officers) and also for co-ordinating the three services, for registration of nurseries and child-minders, and (with the divisional medical officer) supervision of nursing homes. Many local committees claimed time, and programming and interpretation of new policies and techniques called for much preparation. Assistance with research demanded more planning and care in 'getting the message across' to field staff. Divisional nursing officers shared, too, in training of home nursing sisters, student health visitors, selection of health visitor students and of divisional nursing staff, and have assisted in the planning of in-service courses at Grantley Hall. A particularly heavy burden was placed on them when the registration of all play groups was required, and re-registration of nurseries and child-minders.

With the appointment of nursing officers in health visiting, midwifery and home nursing, the co-ordinating, programming, training and public relations roles should take pre-eminence in the work of the divisional nursing officer. She has deeper knowledge of each service supplied to her, and is able to contribute more knowledgeably to discussions on nursing policy. In co-ordinating the needs of three nursing services, more time is available to consider particular local needs. This local knowledge will be needed in as clear a form as possible in the reorganised service of 1974.

The divisional nursing officers are actively promoting more exchange of information between local authority and hospital staffs. They have more opportunity to see what in-service help is needed by staff that local hospitals can provide, and to take steps to improve mutual knowledge.

The overall health education programme in the divisions, in so far as it is undertaken by nursing staff, is the continuing responsibility of the divisional nursing officer.

Her programming function is called upon in relation to new county policies, new techniques and in assistance with research projects. But now she can gain valuable help from the appropriate nursing officer in checking the understanding, acceptance and performance of the programmes by field staff.

Programming and co-ordination come to the fore in relation to health centres—especially the larger ones. Differing groups of nurses commence working together in new surroundings either as part of separate teams or one larger caring group. The overall nursing leadership of the divisional nursing officer settles day-to-day queries and steers the health centre working on to satisfactory lines. Having, with the divisional medical officer, initiated many local authority/general practice attachments, she is known to the doctors working in the centre and her general support is welcomed.

The training duties of the divisional nursing officers continue as before, as does their public relations role between division and other county departments and voluntary organisations.

Divisional nursing officers are encouraged to pursue a subject of special interest, but to date they have been rather fully occupied in assisting their nursing officers develop their right roles.

The nursing management staff at headquarters includes two non-medical supervisors of midwives whose work is supplementary to that of the nursing officers in relation to professional midwifery, and is particularly valuable at this time in liaison functions between maternity hospitals and units.

In some instances, the opportunity is sought for county midwives to use the general practitioner units for certain patients, and in others, opportunities for two-way interchanges of staff so that hospital and domiciliary midwives can appreciate each other's programmes and problems. We are grateful to the many hospitals which accept staff to learn of new hospital methods, to learn something of research and, in the field of general nursing, to introduce nursing sisters to patients prior to discharge. Committee work undertaken by the supervisors gives an opportunity for domiciliary care and thinking to be discussed. It would not be in the best interests of expectant mothers to let the cry for 100 per cent. hospital delivery obscure the need for responsible midwifery care in the field. At present a midwife in domiciliary work knows those mothers for whom she is responsible. Whilst she may not always attend her at antenatal clinic or even at delivery, the continuing responsibility belongs to a specific midwife, and the mother knows she can turn to her with the worries and uncertainties that may or may not affect her total health. If responsibility is mainly in 'the hospital' which, even in the new reorganisation, may be 12 to 15 miles away, a strong support will have been removed. This is particularly important in areas where mothers are too inarticulate to consider consulting their general practitioners on what may appear to be 'little things.' The working partnership between midwives and general practitioners is increasing—even where it is not formal attachment in the general sense.

The principal nursing officers follow the same three broad headings in their nursing work i.e. professional, administrative and personnel functions. One principal nursing officer is concerned solely with health education, and two are

each responsible for a group of divisions in relation to nursing matters. They help to form nursing policy and advise as needed on the implementation of policies in the appropriate divisions.

Training responsibilities include overall responsibility for training for district nursing, continuing development of student nurse community participation, and recruitment to health visitor training. These responsibilities are particularly valuable as they provide a natural means of communication with younger professional nurses and their ideas.

Health centre development in relation to nursing needs, staffing needs, equipment, new techniques, initial registration of nursing homes and continual awareness of nursing developments elsewhere, make the work of the principal nursing officers extremely varied and their time exceedingly full.

The chief nursing officer is very conscious of added support and of more effective communication in the nursing service. She has more time to spend with hospital chief nursing officers in preparation for the discussions which will be needed prior to the start of the new health service. As with other nursing officers, professional, administrative and personnel functions are called for, but preparation for 1974 occupies the major part of her thinking.

DISTRIBUTION OF WELFARE AND OTHER FOODS

Denise E. Robertshaw, Principal Medical Officer

In June, 1970, the Care of Mothers and Young Children and Nursing Services Sub-Committee authorised that a survey be carried out to ascertain the views of mothers following the cessation of the sale of welfare foods through the child health clinics in the Rothwell/Wetherby Division. A copy of the report produced by Dr. W. Duncan Dolton, formerly Divisional Medical Officer for Rothwell/Wetherby and J. B. Worsfold, formerly Research Fellow, Department of Social Administration, University of York, which was published in *Medical Officer*, 1971, *125*, 107, follows:

SALE OF FOODSTUFFS IN CHILD WELFARE CLINICS

This paper describes a pilot survey of the results of total withdrawal of food sales from clinics in a West Riding County Council Health Division. The survey was designed to examine the effects of the policy on: (1) *Local Health Authority staff—both office and field workers;* (2) *the alternative retail outlets—usually shops;* (3) *the consumers—babies and young children, and* (4) *the purchasers—mothers. The paper also describes the changing patterns of baby food consumption and considers whether the need for welfare foods for infants has now passed. Arguments are advanced both for and against the continued selling of foodstuffs in clinics and the pilot division is described to demonstrate that it is typical of the county as a whole. The paper concludes with immediate and long-term recommendations of which the principal one is that no foodstuff should be sold in a child welfare clinic and that alternative arrangements for the sale of welfare foods should be made where possible with chemists who should receive a handling charge for their services.*

Divisional Review, 1967:

A general review of the personal health services was undertaken throughout the county in 1967. The review disclosed in the survey division a pattern of care which bore little relation to the present epidemiological priorities. In particular there was undue emphasis on the nutrition of the baby in its first year of life to the exclusion of services for the toddler and pre-school child. In the School Health Service all children in certain age groups were being seen, rather than children with special need. The review disclosed that about 75% of the district nurses' time was spent with those over the age of 60, and an even greater proportion of the home helps' time. These excellent supportive services were to meet known needs. No attempt was being made to practise preventive medicine with this age group, or to look for areas of potential medical and social breakdown before they occurred.

In the light of this review, the Divisional Medical Officer evolved a three year plan, the aim of which was to put existing child health services in their proper perspective, and initiate services for the aged where none existed—all to be done within the existing budget, with the existing establishment of clerical, medical and nursing staff.

Resulting Administrative Action:

To release medical and clerical staff for other duties and to direct more attention to the school child with problems, routine school medical examinations were abandoned at the beginning of the academic year 1967/68. Some of the medical time saved was redeployed in building up an effective register of handicapped children, with routine six monthly checks for all on the register.

One effect of these measures was functionally to unify the infant welfare and school health service—it being policy to notify officially any child with a potential educational handicap over the age of two. The nursing time saved by these arrangements was completely absorbed within the school health service in increased routine screening for visual and hearing defects, and in health education.

Despite the medical time spent on the handicapped register, the Divisional Medical Officer was able to proceed with plans for six routine developmental assessments for all children during the first five years of life. However, early in the planning stages it became clear that the impediment to the introduction of developmental screening would be shortage of clerical and not nursing or medical time. During the later part of 1968 an unforeseen call on clerical and on the Divisional Nursing Officer's time was the introduction of legislation requiring the registration of child-minders and day nurseries. In 1967 there were four registered child-minders in the division—to date there have been 97 registrations under the Act, each requiring at least two inspections and considerable clerical work in the divisional office.

It became imperative, therefore, to devise ways and means of releasing clerical time to allow developmental screening to proceed in 1969 and to establish geriatric screening at a later date. For some time some medical administrators had been feeling that the need to continue the sale of infant foods in child welfare clinics was now past. Here was an opportunity to save much needed clerical time.

Review of Clinic Food Sales:

By the turn of this century it had become clear that under-nutrition was one of the principal causes of child morbidity and mortality. Subsidized, and indeed free, food was made available through clinics and voluntary societies. Today, however, in the last third of a century marked by technological progress and increasing affluence for the majority, the national problem of adults, children, and even infants is that of over—rather than under—nutrition. There is evidence to suggest, however, that the nutrition of children in low income families may still be inadequate (Newsoms, 1970).

In 1968, £43 m. was spent by the Government on the provision of free or cheap welfare foods (Dept. of Health and Social Security 1968 and 1969), milks and vitamin products. Beneficiaries include expectant and nursing mothers, children up to the age of 5 years 1 month, and certain handicapped children under the age of 16—about 4,366,000 persons in 1968. Distribution is through shops, nursery schools, play groups and day nurseries, as well as the more familiar outlet of child welfare clinics and, in the case of liquid milk, the normal milk supplier.

Our interest has been in the infant and pre-school child who is entitled to either one pint of liquid milk per day, or one packet (about seven pints when reconstituted) of powdered milk per week. The liquid milk costs the purchaser 2½p per pint. The subsidy cost the nation, according to the 1968 figures, £40,583,063 in that year. This figure does not include the expense to the local health authorities of distribution. In this country, liquid milk is cheaper than dried milk and is still widely used over the age of one, dried milk being used only in the first year of life. In contrast to the 187·17 m. gallons of liquid welfare milk consumed in 1969, only the equivalent of 2·59 m. gallons of dried welfare milk were used. It is interesting to note that there has been a steady decline in both the national and local consumption of national dried milk, the equivalent of 4·18 m. gallons being consumed nationally in 1967, 3·35 m. gallons in 1968, and 2·59 m. gallons in 1969. In the West Riding, 94,779 tins of national dried milk were sold in 1966, 81,351 in 1967, and 72,262 in 1968. Nationally, about 8% of welfare food was provided free in 1969 to those in social need who are in the categories above. Vitamin supplements of A and D are available in the form of cod liver oil at 5p per bottle, and vitamin C as orange juice at 7½p per bottle. There is no restriction on the amount of these products that a mother may use for a child entitled to welfare food.

A sub-committee of the Central Health Services Council, under the chairmanship of Sir Wilfred Sheldon, advised its parent committee in 1967 in the following terms: "The sub-committee considers that it need no longer be a function of the child health clinic to purvey national dried milk, proprietary infant foods and cereals" (*Child Welfare Centres*, 1967). The report also recommended "a wider range of distribution points" for foods. Commenting on this *Report on Child Welfare Centres*, Circular 34/68 (Ministry of Health 1968) stated that the Minister was in agreement that foods should not be sold by nursing staff, and branded foods need not be made available in clinics, but the circular went on to say that the Minister "is unable to agree, however, that national dried milk should no longer be sold in clinics . . . and he is concerned to ensure that adequate supplies are readily available for mothers who do not breast feed their babies."

In our research we have noted three claimed advantages for continuing to sell foods in clinics. (1) Expert advice on infant feeding and the choice of product can be given at the time of purchase. (2) Good quality foods are made more available to the public. (3) By subsidizing chosen products, no child need go without necessary food. The first point is that most often advanced by the mothers themselves. We do not feel that where alternative arrangements are made for selling food, this precludes the giving of expert advice on infant feeding by clinic staff. On the second point we would agree with the Sheldon Report that "a wider range of distribution points" will make welfare foods more, rather than less, available, and on the final point we would note that welfare foods have always been available free to beneficiaries in financial need, and, while branded goods could formerly be obtained more cheaply from a clinic than a store, this is no longer the case as many supermarkets are able to undercut clinic prices substantially.

There would appear to us to be six main points to be made in favour of ceasing to sell food in clinics. (1) There will be a saving of extremely valuable clerical and nursing time. (2) The attention of the mothers will be directed from the nutritional state of the baby in its first months of life to the more general idea of interest in its developmental progress from birth to school leaving age. (3) It will allow of valuable space in clinics, at present used for the storage and sale of food, to be used for other purposes. (4) There will be more outlets for national welfare foods than previously. These outlets will be available to the public from 9 a.m. to 5 p.m., including Saturdays, *viz.* during shop hours. (5) There will be some saving of administrative costs, but plainly, the new arrangements will also cost money. (6) Local health authorities will no longer be in commercial competition with food retail outlets—an undesirable state of affairs.

Local Conditions:

The pilot area has a growing population of currently 135,000 persons—the largest divisional population in the West Riding. To the south are three urban areas, formerly coal mining districts, which border on an area receiving an urban aid grant, and real poverty is still not unknown. To the north the population density falls and the area becomes agricultural. There are no major cities within the division, excursions being made to Leeds, Wakefield, Harrogate or York for major shopping, entertainment, and hospital services. As an example, seven out of 10 confinements now take place out of the division in the hospitals in these cities. The division is thus very typical of the administrative county as a whole.

In the pilot area it was decided that no foodstuffs should be sold in clinics after January, 1969. The second half of this paper describes the present reactions to these arrangements of: (1) The local health authority staff, (2) the retail outlets, (3) the mothers.

The immediate reaction, now 18 months ago, was dramatic, and a warning to those who might wish to follow our example. Despite lengthy discussions with health visitors before the policy was implemented, it became clear during the early weeks of 1969 that some HVs were ambivalent in their attitude to the new arrangements. There was considerable hostility from some of the mothers—rather unexpectedly from those who lived nearest to chemists' shops and who possessed cars. With hindsight it is plain that the subject of infant feeding is a highly emotive one in our culture.

Psychological testing by advertizing agencies has shown that housewives associate certain foods with rewards and punishments (Packard Vance 1962). If a product, for example national dried milk, is perceived by a mother to be less 'good' than a competitive brand, she may well prefer to buy branded milk than receive welfare milk free. Motherhood is also strongly linked with the idea of the provider of food, and any apparent attempt to restrict the choice of foods is perceived as a challenge to motherhood. Though many women still feel that breast milk is the theoretical ideal, the vast majority of women now feed their babies artificially. Perhaps it is not too fanciful to suggest that their unexpected aggression may in part be due to a repressed sense of guilt.

When faced with hostility to the new arrangements, the Divisional Medical Officer failed to realize at the time the significance of the 'food provider' situation to mothers, health visitors, voluntary workers and, indeed, health committee members.

Effects of the Policy:

It may have been feared that both the sales of national welfare foods and clinic attendances would fall dramatically as a result of the new policy. However, measured by such objective statistics, the policy has been a success.

From Table I it will be seen that there was a slight fall in clinic attendances of the children under two during the year after the introduction of the scheme compared with the previous year. There has, however, been a 54·8% rise in the number of children attending between 3 and 5 years. In all over 1,203 (15·4%) more children were seen in 1969 than in 1968. Although the birth rate has been slowly falling, in the division there has been no great change in the number of births—certainly the rise in attendances in not attributable to there being more children of this age in the community. Plainly the linked administrative action relating to food sales and developmental assessments has had the hoped-for result—considerably greater care for the toddler and pre-school child.

Table II shows that there has been a 4·1% increase in the sales of national dried milk in the rural districts after the implementation of the new policy. There has, however, been a fall in urban district sales of 21·5% from 1968 to 1969. This, however, should be compared with the fall in milk sales in the West Riding as a whole, of 26·9% between 1968 and 1969. There has also been an overall fall in sales of orange juice and cod liver oil, but it is interesting to note that there has been a 5·4% increase in orange juice sales in the first nine months of 1970 compared with the same period of 1968, before clinics ceased to sell these products.

There are two possible explanations for the rise in the sales of national dried milk and welfare orange juice in the rural districts, the first being the simple one that the new arrangements have made the products more accessible to mothers. In the case of orange juice this explanation is likely to be correct, but it is also true that by removing branded milks from clinics we have left mothers resident in rural areas with no alternative but to buy national dried milk, with the consequential increase in sales.

We would like to be able to produce equally hard statistics on the effects of the policy on nutrition of babies within the division. This, however, is beyond the scope of such a pilot survey. We would only comment that there is no evidence whatsoever that the children born in 1969 were in any way developmentally inferior to those born in 1968. Even if routine weighing of babies were still a clinic practice, which it is not, we should doubt that the weight of babies was an accurate index of their nutritional status. The most recent nutritional survey of which we are aware has shown that obesity in the children of Rotterdam is now

most common in the lower social classes. We know, however, that many beneficiaries entitled to free national dried milk are not obtaining it, as only 4·5% (369 packets) of the national dried milk issued in 1969 in the division was free compared with 8% issued free in England and Wales in the same year. We are of course chiefly concerned for the nutrition of the socially under-privileged child but feel that routine developmental assessments followed by advice on nutrition and how to get free welfare food, are more likely to be beneficial than merely having packets of national dried milk in the clinic available on request. These mothers do not normally attend child welfare clinics (Spence and Miller 1954; Office of Health Economics 1967). The argument that the removal of subsidized branded foods also penalized the children of the poor is untenable. Such mothers often have money only on pay day and cannot wait until the next clinic to buy subsidized foods. They tend to spend at the local chemist's shop when the money is to hand.

1970 Survey:

Local Health Authority Staff:

Before the new scheme was introduced, two clerks were employed for half their time in this service. There were in addition three paid helpers in clinics for the sale of foods. It is estimated that no less than 40 hours of clerical time per week were required within the division to administer the 'orthodox arrangements.' In addition most health visitors were directly or indirectly involved in the transport or sale of foods. It is much more difficult to get an accurate estimate of the time spent by health visitors, but there were regular complaints about having financial responsibility for sales in the clinics. The opinions of all members of the staff involved have been sought and are now summarized.

The clerical staff are unanimous in preferring the new arrangements. The Divisional Administrative Officer now makes monthly checks only where the distributor asked for this, the general policy being that outlets are visited as needed. In practice 15 centres out of 44, scattered as they are over a wide area require about 10 hours visiting per quarter. The Divisional Administrative Officer is accompanied by a clerk who now undertakes the entire welfare food sales clerical work for the division. Her day-to-day duties involve not more than 20 hours per week. The health visitors are no longer involved in any way with the sale of foods. Their reactions are mixed. Some feel, like the Department of Health, that the health of infants may suffer. They were totally unable however, to produce one case to substantiate their arguments. Several health visitors felt that subsidized foods were used more widely by mothers in the higher and middle income bracket than the lowest paid for two reasons: first, on the whole the less educated mothers do not visit clinics regularly and, second, they did not have the ready cash to buy even subsidized foods. Some felt that the new arrangements were an inconvenience to mothers and 'unfair' on the grounds that other divisions in the West Riding still supplied subsidized foods.

It should be noted that the cities of Wakefield and Leeds, which are the natural shopping centres for the majority of the population, ceased to sell subsidized foods in clinics several years ago. The majority of health visitors felt the scheme to be an entire success and had no reservations. The survey of mothers' opinions of course attempted to establish how real were the economic and physical hardships caused by the new arrangements.

Table I

Clinic attendances in pilot division

		Children Under one year		*Children One but under two*		*Children Two but under five*		*Totals*
		Rural districts	*Urban districts*	*Rural districts*	*Urban districts*	*Rural districts*	*Urban districts*	
Year	1968	1649	919	1570	1013	1522	1122	7795
	1969	1577	900	1511	915	2392	1703	8998
Change		—72	—19	—59	—98	+870	+581	+1203
% change		—4·3%	—2·1%	—3·8%	—9·6%	+57·2%	+51·8%	+15·4%
% change England 1968/69		—1·8%		—0·9%		—1·4%		—1·4%

Table II

Welfare food sales in pilot division

		Packets of national dried milk		*Bottles of orange juice*		*Bottles of cod liver oil*	
		Rural districts	*Urban districts*	*Rural districts*	*Urban districts*	*Rural districts*	*Urban districts*
Year	1968	4215	4865	17063	18504	670	1129
	1969	4387	3819	18631	14138	528	812
Change		+172	—1046	+1568	—4366	—142	—317
% change		+4·1%	—21·5%	+9·2%	—23·6%	—21·2%	—28·1%
% change England 1968/69 ...		—24·9%		+9·6%		—4·7%	
% change West Riding County Council 1968/69		—26·9%		+12·4%		—6·1%	

Maternity Hospital Staff:

Seven out of 10 babies within the division are now born in St. James's Hospital and the Maternity Hospital at Leeds, the Fulford Maternity Hospital, York, Manygates Hospital, Wakefield, and the Harrogate General Hospital. The matrons of these hospitals were asked what advice they gave on infant feeding to mothers confined in their hospitals. All actively encouraged breast

feeding and none encouraged bottle feeding, but the final choice was left with the mother. For administrative reasons mothers who were artificially feeding their babies were not given a choice of milks, all artificially fed babies being discharged on the product preferred by the hospital. It is interesting to note that each hospital sent out artificially fed babies on a different milk product, *viz.* Carnation, Cow and Gate, Ostermilk, National Dried Milk and Trufood. Plainly this can be expected to have an impact on feeding practices when most mothers leave hospital artificially feeding their babies.

Retail Outlets:

Of the 44 welfare food distribution points in the Division only six are now managed by staff or voluntary helpers. The remaining 38 outlets are in shops or, exceptionally, family doctors' surgeries. For the survey 16 of these 38 (42% sample) retailers were interviewed personally by the sociologist in the survey team; four of these were grocers, 10 chemists, and two post office managers; a family practitioner running a welfare baby clinic which also sells foods was also questioned. The survey retailers had been selling welfare foods for a period of time ranging from five months to over 12 years.

Questions designed to explore how the retailers felt about the arrangements exposed the need for more adequate briefing. In the survey group seven of the 16 had been approached in the first case by a health visitor, five by the Divisional MOH in person, and four by another member of the divisional staff or the local family doctor operating in the area. Some of the retailers had taken on the responsibility as a service to the community, others because there was no clinic in the area. On the whole the interviewer's impression was that the arrangements made were recalled as rather vague with little initial explanation as to what was involved in welfare food distribution and very little explanation with regard to token sales or regulations governing eligibility for free or reduced price foods.

When asked if they were satisfied with the present arrangements, 11 of the sample expressed complete satisfaction. Of the five who said that they were not, two felt that there should be a handling charge to cover overheads, incidental expenses and selective employment tax, and this amount should be related to volume of sales. The other three had varying difficulties, which in fact need not have arisen. One for example, would have preferred to have sent money by cheque rather than cash to the divisional office, an arrangement much preferred by the divisional office and already practised by other retail outlets. These dissatisfactions again emphasize the need for good communication, both at the start and during the running of such an agency scheme.

Ten of the sample retailers stock all four welfare food products—milk, orange juice, cod liver oil and vitamin tablets. Two did not stock national dried milk and the other four did not stock cod liver oil and vitamin tablets, on the grounds that there were not sufficient sales to ensure reasonable stock rotation.

The times available for the sale of welfare foods did not vary greatly and were usually from 8-30 or 9 a.m. until 5-30 or 6 p.m. on five days a week, with a variety of half-day closing times mid-week and on Saturdays. Most of the retailers also had at least one late night mid-week closing time, usually to 7 p.m. Generally, it seemed that mothers had ample opportunity for buying their welfare and other food products.

When asked about administrative difficulties, 11 retailers said there were none, but some retailers found difficulties in keeping accurate accounts and two specifically mentioned that they did not fully understand who were entitled to free and reduced price welfare foods.

When questioned whether mothers bought welfare foods as often as branded products, 11 of the sample were quite emphatic that mothers preferred the branded foods. One was not sure and the other four stocked only welfare foods and so were not able to comment. It is quite clear, therefore, that where a free choice is given to mothers they will take a branded product in preference to the welfare equivalent. In the opinion of the retailers there were several reasons for this preference. They mentioned specifically the effect of advertizing and that hospitals generally preferred branded milk to national dried milk. Retailers estimated that for every one packet of national dried milk six packets of Cow and Gate and 12 packets of Ostermilk were sold. One respondent said he sold two packets of national dried milk to a case of Ostermilk. National dried milk was plainly regarded as an inferior product, in one respondent's words "national dried milk is a dead duck". With regard to vitamins A and D, drops (for example Adexolin) were usually preferred by mothers, because the price was reasonable and it was more readily taken by the children than cod liver oil. On the whole the surveyed retailers felt that mothers thought the branded products were of better quality than the welfare foods and there was some stigma still attached to the latter. Orange juice was the only welfare food that was felt to be of comparable quality to commercial products; in several cases sales were in fact higher.

Asked what changes in the distribution of welfare foods they would like to see, half of the sample replied they were satisfied with the present arrangements. Four again mentioned the need for some financial incentive, one stressing the need for advertizing and one expressing annoyance at having to complete official forms.

We tried to get from the retailers some indication of what proportion of the local population, eligible for welfare foods, was not taking up their benefits. The question was intentionally open-ended and there was obviously a wide variation in the reliability of the replies. Five respondents felt that the majority of the people in the area were receiving benefits, five had no idea at all, two thought the great majority were receiving benefits, one felt a large number were not receiving their entitlements, and another suggested that a quarter of those eligible failed to take up their benefits.

The following analysis of the mothers' questionnaires will of course demonstrate which of these perceptions of truth is correct, although there might be varying uptakes in different areas.

Questioned further about the uptake of welfare foods, respondents stated that some families on supplementary benefits preferred to pay extra and use Ostermilk. They stated that some mothers had not even heard of the benefits, and that others were not interested and there was no advertizing to stimulate and inform them. There is, of course, advertizing and publicity relating to welfare foods displayed in almost every clinic in the country. It would seem that advertizing material suitable to the chemist shop should be produced if the pilot scheme is to be nationally adopted. In reply to the question, "Now that you are selling welfare foods do you think people come in specifically to buy these foods, or that they would be coming to you for other products in any case?", five respondents felt most came in any case. Six replied that mothers came specifically to buy welfare foods only. Three felt that the reasons for coming were equally divided. One felt 80% came to buy welfare foods and the remaining respondent felt 90%. Clearly there is a wide range of opinion within the sample surveyed.

The interview ended with an opportunity for the retailers to make any comments they wished. Six took the opportunity to stress the need for payment. A comment was made that they thought this should be a public service. They did not expect to give their time and professional advice free but felt they should be paid for it as it was obvious to them that divisional staff were being released for other duties within the national health service. Three saw the service as being more convenient for the consumer and two felt strongly that the chemist shop was the correct place to sell welfare foods and not other outlets. One was not quite sure how to react to a final comment that the survey was "a good idea, timely, and well needed"!

MOTHERS:

It is the mothers of the 2,350 babies born in 1968 in the pilot division who ultimately determined which foods their babies received. Their opinions and preferences concerning baby foods and the place of sale are of as great importance as the objective measurements of milk sales and clinic attendance.

Mothers with a baby born in 1968 were thought likely to have had experience of food sale arrangements before and after the policy changed. A random sample of 500 was drawn and questionnaires and addresses given to local secondary schools who had agreed to provide interviewers. After simple briefing, senior schoolgirl volunteers successfully interviewed 294 of the 418 mothers to whom questionnaires were finally given out, a 13% sample of those confined in 1968.

Of the 124 non-responders nearly half had moved outside the district or were outside the study area: 10% of the remainder refused interview, 10% were away from home and 33% were ineffectual visits. It would seem reasonable therefore to claim a 'corrected' response rate of 83%.

The 294 interviewed mothers appeared a typical sample of West Riding mothers as a whole, when compared with the Registrar General's figures for date of birth and family size. The place of birth of the 530 children of the survey mothers was also typical of the division as a whole, about 30% being born at home and the remainder in the five hospitals mentioned.

Although the 83% response rate and the inexperience of the schoolgirl interviewers must limit the value of this part of the study to some extent, the results are nevertheless of great interest.

Mothers were asked about their use of milks, vitamin C and vitamin A and D products. Their choice of milk is shown in Table III. The great majority preferred Ostermilk and national dried milk was only the third in order of preference with 15% of the respondents. This raises the question whether welfare food tokens should not be made available for any dried milk product of the mother's choice and not only national dried milk.

TABLE III

Feeding practices of survey mothers

Breast feeding			12
Artificial	Ostermilk	124	
	Cow & Gate	60	
	N.D.M.	44	
	S.M.A.	20	
	Trufood	15	
	Carnation	10	
	Cow's milk	5	
	Other	4	
		282	282
Total sample			294

About one-third of the mothers started breast feeding and 12 (4%) breast-fed exclusively and weaned directly on to liquid cow's milk. Most mothers stopped artificial dried milk feeds between six and nine months but it is interesting to note that several mothers continued dried milk feeds up to the second birthday. Four out of five (232) mothers continued with the milk they started the baby on; those who did change seemed to prefer Ostermilk or cows' milk (Table IV).

TABLE IV

Pattern of artificial feeding

Same milk throughout			232
Changed to	Ostermilk	14	
	Cow's milk	14	
	Cow & Gate	7	
	S.M.A.	4	
	N.D.M.	2	
	Trufood	1	
	Carnation	0	
		42	42
No reply			20
Total sample			294

Whatever one's views on the desirability of breast feeding, it is reasonable to assume that artificial feeding with branded milks is at least as suitable as with welfare milks. However, the situation is rather less satisfactory when we consider the use of branded vitamin C products. At the time of interview 85 (28%) mothers were using welfare orange juice for their two year olds and 75 (25%) for the rest of the family under five. Half (145) were giving commercial vitamin C containing alternatives; however two mothers mentioned cod liver oil and one each tea and coffee and Minadex as sources of vitamin C. The full list of their choices is found in Table V. Apparently one in five mothers do not give vitamin C supplements in any form.

TABLE V

Commercial vitamin C products used by mothers

Ribena	44
Commercial orange juice	36
Delrosa	24
Rose hip	10
Blackcurrant juice	9
Optrose	7
Fresh oranges...	5
Tree Top Orange Juice	3
Cod liver oil	2*
Haliborange	1
Orange pop	1
Fruit juice	1
Minadex	1*
Tea and coffee	1*
Total	145

*Mother's reply

Under half the survey mothers gave vitamin A and D containing products to their babies, and 107 (36 %) preferred the commercial products (Table VI); again three mothers were in error in giving Optrose and Rose Hip Syrup in the mistaken belief that they contained vitamins A and D. The choice of the other mothers, however, was sensible and would provide an adequate supply of vitamin D. Only 26 (9 %) mothers gave welfare cod liver oil to their two year olds, and 20 (7 %) gave it to the rest of the family under five—remarkably similar proportions to those reported in 1960 when only 8 % of entitled persons took their cod liver oil (Office of Health Economics 1967).

TABLE VI

Commercial vitamin A and D products used by mothers

Haliborange	17
Adexolin	14
Cod liver oil and malt	9
Abidec...	7
Virol	3
Seven Seas	2
Minadex	2
Optrose	2*
Rose hip	1*
Not specified	50
Total	107

*Mother's reply

Clearly, the mothers much prefer commercial vitamin products to their welfare equivalents. The fact that one survey child in five had no vitamin C supplement of any sort, and one child in two no vitamin A and D supplement, must be a cause for concern. These findings by themselves do not support the assumption that the vitamin intake of these children is necessarily inadequate for their requirements. Sophisticated nutritional studies would have to be undertaken to confirm or refute this.

Questions designed to explore the effects of the policy change revealed that of mothers replying to this question 60 (43 %) bought the same amount of national dried milk after the change as before, while 50 (36 %) bought less and 31 (21 %) bought more. Seventy-three (47 %) mothers said they bought less welfare orange juice, 45 (29 %) bought more and there was no change in the buying habits of 41 (24 %). Thirteen (13 %) mothers replied that their purchasing of cod liver oil had not changed, 3 (3 %) said that they had bought more, but 84 (84 %) said that they bought less.

TABLE VII

Mothers' reasons for preferring shop or clinic for food sales

Mothers prefer to get welfare foods in shops because:		
	You go there anyway to buy other things	44
	They are open longer	42
	They are easier to get to	33
	Foods are cheaper	9
	Wider choice of baby foods	3
	Other reasons	4
Mothers prefer welfare foods at clinic:		
	To meet the health visitor	81
	The foods were cheaper there	47
	You went to the clinic anyway	39
	Easier to get to	18
	Other reasons	10

The survey attempted to distinguish between the changed purchasing habits of mothers and their satisfaction with the new arrangements. Mothers on the whole preferred the orthodox arrangements for the sale of food from the clinics. Table VII gives the reasons given by the 160 mothers who said they preferred to get the food in clinics and also those of the 92 who preferred the shop arrangements. Some mothers gave more than one reason for their preference, and some interviewers had recorded incompatible preferences making interpretation difficult. However, when asked the simple question if the present arrangements were liked, 139 (47%) respondents said "No" and 122 (42%) "Yes".

An objective assessment was made of the travelling time or distance between the clinics and food shops visited by the mothers in our sample. The findings can be seen in Tables VIII and IX from which it will be seen that there was little difference in length of journeys. While the 'distance factor' has not been very significant in this survey, clearly the 'convenience factor' of much longer opening hours has made foods more accessible from shops than clinics.

The amount of money spent by each family in a week on the purchase of national welfare foods as opposed to equivalent commercial products was investigated. An arbitrary upper limit of £2 per week for family spending was set for the survey, and the figures converted to new pence so that future calculations could be made more easily. It appears in our sample that up to 20 new pence per week the families spend slightly more on national welfare foods. In

the spending range 20 to 60 new pence per week roughly equal amounts are spent on branded and welfare foods. In the range from 70 to 200 new pence per week there is a preference for commercial food. It was not possible from the data to confirm or refute the suggestion that mothers on supplementary benefit or near benefit levels were preferring to spend money on branded foods rather than receive free the national welfare equivalent.

TABLE VIII
Distance to food supplies

Distance in miles	*Number of mothers travelling*		
	To clinic	*To shops for national welfare foods*	*To shops for branded foods*
¼	7	4	5
½	19	21	13
¾	2	4	6
1	25	15	14
1½	8	6	3
2	11	8	5
3	11	5	9
4	2	2	1
5	4	9	9
Total	89	74	65

TABLE IX
Journey time to food supplies

Time in minutes	*Number of mothers travelling*		
	To clinic	*To shops for national welfare foods*	*To shops for branded foods*
5	83	94	88
10	40	48	40
15	31	26	14
20	14	22	14
30	7	2	1
Total	175	192	157

Discussion:

Clearly, the primary objective of the administrative decision to stop food sales in clinics has been achieved—the saving of clerical time. There have also been other savings of health visitors' time and clinic space. Objective assessments of clinic attendance and food sales suggest that there have been no adverse repercussions on the health and welfare of the children under five in the pilot division.

The survey had disclosed that while Local Health Authority staff and retail outlets liked the new arrangements the majority (47%) of mothers did not. Mothers particularly felt their access to Health Visitors to be threatened (Table VII).

We were concerned to note that one in five mothers were giving no vitamin C supplement of any kind and half no vitamin A and D supplements. Unfortunately we were not able to see whether the subsidized welfare foods were being used by those who need them to maintain adequate diets. The low uptake of free milk in the division is a cause for concern, and similar findings are reported nationally by Lafitte *et al.* (1970). Medical officers and health committee members in the north of England can take little comfort from the knowledge that milk consumption is already half a pint per day less per head in the north compared with the south of England. Steps must be taken to ensure that the recently announced cuts in social service and welfare food expenditure do not react unfavourably on the health of children whose parent's earnings are at or below supplementary benefit level. We would suggest that the time has come to discontinue all welfare foods except for those families entitled to supplementary benefit and low income families where the father is in full-time employment. At present about 600,000 mothers and children are eligible for free milk on grounds of hardship or of family size. The government expects the number to increase to about 750,000. For these families tokens should be provided for free foods, the mother choosing from a list of 'approved' commercial milks and vitamin products. Long term arrangements can only be made by negotiation with the local authorities, the food trade and the Department of Health and Social Security.

Recommendations:

(1) All foods including national welfare foods should cease to be sold in clinics to allow for the development and extension of health staffs' professional services.

(2) The primary outlet for the sale of national welfare foods should be chemists' shops or, when these are not available, the village general store.

(3) Five per cent. of gross turnover should be paid to the retailer for a handling charge.

(4) All milk tokens should be exchangeable for commercial powdered milk as well as to national dried milk.

(5) Welfare cod liver oil in its present form should be discontinued as a viable source of vitamin D supplement, and a more acceptable product developed.

(6) Welfare orange juice as a vitamin supplement should be better packaged and better advertized. This product should also be placed on a competitive basis with similar commercial brands, and if it is proven that it cannot hold its own in sales against other brands, then production should cease.

(7) A cheap bulk form of powdered milk should be made available by manufacturers to offset the predicted rising cost of liquid milk for family feeding.

(8) Child welfare clinic staff should be actively encouraged to continue their contact with mothers when they have ceased to sell welfare foods, as it appears that the feeling of ready access to the health visitor is important to the mother. Staff must be made to see that their role is enlarged rather than diminished by these measures.

(9) Routine developmental assessments must be considered an integral part of an intermediate scheme to sell welfare foods from shops or long-term scheme to issue only free milk to needy families. Regular checks on the nutritional state of children will be important at least until we can be sure there are no adverse effects on diet.

Acknowledgements:

We are pleased to acknowledge receipt of research grants from the Research Group of the Society of Medical Officers of Health and from the West Riding County Council. We thank the staff and senior girls of Garforth Comprehensive School, Rothwell Grammar School, Stanley Secondary Modern School and Sherburn and Wetherby High Schools for arranging and undertaking the interviewing of the mothers. We have received encouragement, guidance and support from Dr. R. W. Elliott, County Medical Officer, West Riding County Council and Prof. Margot Jefferys, Bedford College, London; to them and the clerical staff who have contributed to this report we express our indebtedness. The views expressed in this article are our own, they are not necessarily those of any person or bodies with which we are associated.

References:

Central Health Services Council, Standing Medical Advisory Committee, *Child Welfare Centres*, pp. 21-22. H.M.S.O. 1967.

Department of Health and Social Security, Annual Reports, 1968, 1969. H.M.S.O. 1969, 1970.

Lafitte, F., Holman, R., Spencer, K., Wilson, H. *Socially Deprived Families in Britain*, p. 187 Bedford Square Press, 1970.

Ministry of Health, Circular 34/68, para. 8, 1968.

Newsom, J. and E. *Four Years Old in an Urban Community*, p. 218. Pelican Books, London, 1970.

Office of Health Economics, *Malnutrition in the 1960s*, pp. 27-28 O.H.E. London, 1967.

Packard, Vance, *The Hidden Persuaders*, pp. 86-87. Penguin Books, London, 1962.

Spence, J. E., Miller, F. J. W., *A 1,000 Families in Newcastle on Tyne*, pp. 163-172. O.U.P., London, 1954.

Following the experimental cessation of all types of food in clinics in the Rothwell/Wetherby area, a second trial was carried out on similar lines in the Harrogate area of the County by the Divisional Medical Officer, Dr. Hepple, and a copy of his report appears below:

THE SALE OF NATIONAL AND PROPRIETARY WELFARE FOODS REPORT BY DR. N. V. HEPPLE, DIVISIONAL MEDICAL OFFICER (HARROGATE)

For some years prior to 1971 the arrangements for the sale of branded and national welfare foods had been giving concern both to the nursing staff at the various centres and to the clerical staff concerned with its administration. The principal reasons for this concern were:

(1) The considerable sales of Rose Hip Syrup at a price very much less than that in the shops coupled with the report of the dental authorities regarding its effect on infants' teeth.

(2) The great majority of mothers used the centre as a shop, often calling to collect welfare food without their child, relying on the baby weight card to establish their bona fides.

(3) The limited hours of availability.

(4) The unrealistic amount of time spent by the nursing staff on clerical work in centres where clerical assistance for sales was not provided.

(5) The amount of time spent by clerical staff in checking and rectifying the accounting from centres.

(6) The growing numbers of general practitioners who were setting up their own 'well baby clinics' in their surgeries and requesting welfare food facilities.

It was therefore decided early in 1970 to pursue an experimental course by asking health visitors in charge of the various centres to publicise the fact that certain selected items from the authorised branded welfare foods list would not be re-ordered when present stocks were exhausted. The reactions of the public were reported by the health visitors at subsequent monthly meetings. Very few health visitors reported criticism but rather reported a general acceptance of the principle.

It was therefore decided that after 31st December, 1970, no further branded baby foods would be ordered and sales would cease when stocks had been sold and sales would cease completely on 12th February, 1971.

There still remained the problem of the National Welfare Foods. As mentioned previously, it had long been felt that the limited opening hours of the centres offered nothing but a token service to the public and ideally this should be available through chemists or other retailers. Initial enquiries revealed that the chemists were hard-pressed for shelf space and were unwilling to speculate by selling national welfare foods in the hope of attracting more potential customers into their shops; neither were they prepared to undertake the minimum clerical work involved. It was necessary, therefore, to look elsewhere. By chance it was noted that, of the Child Welfare Centres in the town, all were within a hundred yards or so of a branch of the Harrogate and District Co-operative Society Ltd. The D.A.O. in September 1970 had a very informal conversation with an assistant manager of the main branch to estimate the possible reaction of the directors to the suggestion that the Co-operative Society undertake the sale of national welfare foods in all its branches. In spite of the fact that no handling charge would be paid and a certain amount of clerical work would be involved, the assistant manager considered that it would be worth pursuing this line. In October another informal meeting took place between the same individuals when it was learned that a formal approach would be accepted for putting before the directors and committee. This approach was made in November and formal acceptance of the principle was accepted by the governing body of the Co-operative Society in December. A series of subsequent meetings took place at which the details regarding coupons and the type of beneficiaries were outlined and a reference sheet was prepared for each check-out at the branches. It was agreed that 'D' Day, 15th February, 1971, would be a very suitable date for the commencement of the new arrangement.

The Co-operative Society then held a meeting of their branch managers and quite a number expressed their reluctance at having to accommodate yet another commodity on their already overcrowded shelves.

There were teething troubles in the first few weeks but these were of a very minor nature and principally those connected with maintaining supplies. There was also some misunderstanding regarding the types of coupon and the range of dates acceptable on dated coupons, but this was not a lasting difficulty and quickly cleared when the milk tokens were withdrawn. Bulk supplies are delivered to the central clinic and stocks are replenished as necessary by hired transport. Delivery notes are left with the branch managers and a copy is retained in the Divisional Office.

The administrative procedure has been simplified and now two stock checks every quarter are made by responsible persons from this office usually taking about $2\frac{1}{2}$ hours to visit the nine branches concerned. After agreeing the stocks with the branch managers a summary with individual stock sheets in respect of each branch is forwarded to the Co-operative Society's main office and a single cheque to cover all sales from all branches is returned to this Department within about 14 days.

These arrangements provide a comprehensive service to Ripon City, Knaresborough and Harrogate and, in the case of Ripon City, have created an additional distribution point in the rapidly expanding housing area of Lead Lane. Harrogate has also gained three additional points, one near the new Health Centre, one in the Bilton area and the third in the area to the south east of the Stray whose mothers had previously to travel two miles to obtain welfare foods. The Co-operative Society shop at Poppleton is a branch of the York Society and the Manager pays over the amount due at the time of the stock check. The rural areas continue to be served by the existing arrangements with village shops.

A recent review of the situation with an assistant manager at the main branch revealed that, without exception, all branch managers are more than happy with the arrangement. All branches reported an increase in sales over and above the amount accounted for by the welfare food sales. (During the last two weeks of February sales of the branded milk foods increased so much that the main Co-operative supply depot could not meet the branch orders for Cow and Gate).

Comparative figures for quarters ending 30th June, 1970 and 1971 are given below:

	Quarter Ending 30th June		
	1970	1971	Percentage +or—
National Dried Milk	412	641	+55·6
Cod Liver Oil	243	338	+39·5
Vitamin A & D	600	485	—19·1
Orange Juice...	10,441	11,285	+ 8·0
Vitamin Drops	Nil	242	

——oOo——

Comments

Both reports remark that the usage of other outlets for food sales has released staff for other duties; administrative staff now spend less time per month on food sales. A survey of health visiting work in the County, carried out from 6th April to 15th May, 1970, revealed that 95 health visitors and 16 assistant health visitors were involved in the sale of foods and this survey did not seek to establish the number of clerical staff also involved; 25·1 per cent. of health visitors' time and 19·5 per cent. of assistant health visitors' time was spent on clerical work (about a third of which it was considered could be done by clerical staff).

In the Harrogate area, there was an increase in the uptake of both National Dried Milk and proprietary foods. The use of branches of the Co-operative Society as distribution centres has eliminated difficulties regarding a handling charge pressed by the chemists in the Rothwell/Wetherby area.

Some of the recommendations in the report of Dr. Dolton and Mr. Worsfold have already been implemented by the Welfare Foods Order, 1971, which came into operation in April, 1971. Under this Order, cheap welfare milk for all expectant mothers and children under five years was withdrawn, but expectant mothers with two or more children under school age and families with three or more children under school age continued to be entitled to seven pints of liquid milk or one pack of National Dried Milk per week for the third and each additional child under school age regardless of income. In low income groups, any expectant mother and all children under school age are entitled to the above free of charge, plus free Vitamin A, C and D drops which have replaced cod liver oil and orange juice for children and free Vitamin A, C and D tablets for mothers. The cod liver oil and orange juice were withdrawn as a result of recommendations of two panels set up by the Chief Medical Officers' Committee on Medical Aspects of Food Policy, one of which recommended that a more palatable form of Vitamin A and D than cod liver oil should be found and the other considered that the misuse of undiluted fruit juices (including welfare orange juice) was conducive to rampant dental caries.

Whilst the West Riding clinic sales of National Dried Milk have been falling (72,262 in 1968: 38,664 in 1971), there has been an increase in the uptake of free National Dried Milk.

	Paid for	*Free*
Quarter ended 28th March, 1970	10,350	1,306
Quarter ended 28th March, 1972	7,999	1,630

The Department of Health and Social Security also reports an almost 50 per cent. increase throughout the country in the number of people receiving one pint of free welfare milk a day between April, 1971, and October, 1971. It would appear that the Welfare Foods Order has increased the uptake of free welfare food by those in need. However, in the Rothwell/Wetherby area, there has been a slight fall in the sale of National Dried Milk. The present Divisional Medical Officer reports that, in the quarter ended December, 1971, sales of National Dried Milk were 1,874 and in the quarter ended March, 1972, they were 1,627. She states that some shops and chemists have expressed disgruntlement at the lack of payment of a handling charge.

Local health authorities have a duty to make adequate arrangements for the distribution of welfare foods, i.e. National Dried Milk, Vitamin A, C and D drops for children and Vitamin A, C and D tablets for mothers, although this does not necessarily mean this should be done at child health clinics. The sale of proprietary products is at the discretion of the authority.

If Divisional Medical Officers were allowed to discontinue the sale of proprietary foods and, in addition, were allowed to make alternative arrangements for the sale of welfare foods where this is possible, then this would relieve some of the burden placed on professional and clerical staff at the present time.

A PYRAMIDAL STRUCTURE FOR HEALTH EDUCATION IN SCHOOLS

Elizabeth M. Harvey, Departmental Medical Officer

My interest in health education has been developing over many years and arose out of my school medical work. In that context the lack of understanding of even simple principles of healthy living was obvious and in the discussion of various school health problems with heads of schools and with teaching staff, it became evident to me that understanding of health material is a more specialised activity than I had previously realised. Consequently, I began explaining to pupils and their parents, some principles of health; later I would have liked to extend this to groups, but little interest was shown, and nothing was accomplished. There was, however, one area of considerable interest, that relating to hazards to health amongst older school pupils. In effect, this amounted to a frightened cry from secondary schools, "Please come and stop our older girls getting pregnant, prevent our boys and girls getting V.D., and if you really think it matters you can talk about hazards of smoking too". For some years I responded to these requests, but with increasing dissatisfaction and doubt. To me, no last-ditch semi-attempt to save the school from getting a bad name was adequate help for the pupils and could indeed prove dangerous. This sort of work, in my opinion, could under no circumstances be glorified by the name of health education.

Joining the West Riding in January, 1970, was, therefore, something of an adventure for me. I was now to have the opportunity to see in two health divisions, health education work, undertaken largely by health visitors, backed by an experienced central office staff with technical assistance and a library of visual aids of several years' development. Since I was not participating in clinic work, I paid scant attention to health education there, confining my study to health education in primary and secondary schools.

In most primary schools little attempt was being made at any health education. In some of the 'more enlightened' schools a short programme of work was being undertaken with the senior girls, to deal with menstruation and growing up, sometimes organised with mothers present. No concern for boys was anywhere in evidence. In a few schools, the health visitor taught a little hygiene, and community health and care. Some teachers and parents considered teaching sex education, but in only one school did I find a comprehensive programme of sex education, which was far and away the best sex education work I have seen anywhere; it was the school's health visitor who drew my attention to this work.

The work in secondary schools varied considerably. There were new comprehensive schools which taught no health education. At the other extreme, one school had a team of teachers under the able leadership of the head of the biology department. They had a comprehensive course incorporating general principles of personal and community health including personal relationships,

sex education in the context of general development and maturing responsibility. The course included talks on sexually transmitted diseases and the misuse of medicines, especially those causing the present drug problems. Teachers met regularly to discuss the problems which arose and invited their school health visitor to join them. Other schools co-operated with their health visitors in courses about menstruation for their 12 to 13 year old girls, but I found no concern for problems facing boys; however, boys were included in domestic science classes in many schools. In a few schools, the least academic children were involved in what is generally described as a humanities course; individuals of either sex could study home economics, woodwork, metalwork, decorating, gardening and other activities that can aid good homemaking. Throughout my study area much more effort was made towards helping the pupils least equipped academically. I was told that able pupils, being able, could manage on their own; it was far more important to attend to their examination curriculum work, after all, that involved their whole future. In some schools, an attempt was made to acquaint the early school leavers with possible hazards to their health, like V.D., smoking and drugs; and in a few schools, likewise, opportunity was made to discuss such matters with the sixth form leavers. Whenever I personally had opportunity to discuss with senior pupils themselves, I asked them what information in health matters should be theirs before leaving school. Both early leavers and 'A' level pupils agreed that information about reproduction; personal relationships; sexual relationships and contraception; diseases transmitted sexually; and the use and abuse of medicines should be given to all pupils at the very latest by the age of 13 years. This information was sought so that they might know why, as well as how, to live healthily. I was twice asked to arrange classes for parents, so that they could more ably help their sons and daughters. Potential university male students asked me earnestly for the opportunity to learn how to care for their flats, their clothes and food, and both boys and girls wanted advice on the management of student finances, academic, physical and personal well-being.

All these efforts I was glad to see, and gladder to assist. What I found abysmal was the complete lack of any graded and progressive teaching in health education. Were any subject regarded of curriculum standard to be approached so fortuitously, it would reap the deserved reward of non-interest in the taught. I do not believe that teachers, or any other people, hold personal and community health in contempt. What I am sure of is very simple, really. Health matters are known and understood by people trained to understand them, and this does not include the teaching profession; why, indeed, should it? In secondary education, specialist training in various disciplines is recognised, and those not having that specialised training are not expected to handle that subject. It is patently absurd and dangerous to suppose that teachers with no special health training can handle health material without the help of specialists in health and disease. Indeed, why should teachers ever assume the responsibility of teaching what it has taken doctors and health visitors at the very least five years of whole-time training to learn? Why? Because the teachers are the ones who understand teaching, are trained for it, and know how to impart knowledge in a

way that makes the material fascinating, and infinitely worth remembering and living by. It has been my concern, therefore, to work out a system of health education for schools which will enable teachers to introduce health material at any place in their day-to-day work where it can arise in context, and to make the framework for co-operative help from those whose business is health to give the health knowledge and understanding to those whose business is education. Living is inevitably a community effort, and an inter-communicating effort to boot, and I see no possible reason why health/education team work should fail to improve our health understanding, and thence our general enjoyment of living.

Health education has often seemed to me to be understood in a limited way. I believe that the least we should attempt is to give every school leaver the ability to say "My health in my hands", assured that he knows enough of himself and his environment, and the interaction between them, to keep himself in good health, recognising and seeking help as soon as his own knowledge and ability cannot deal with a situation. To equip schoolteachers with sufficient knowledge of health material to attain this standard would greatly lengthen their training period. My suggestion is, therefore, that help to attain this level of health understanding can be made available to teachers by using the pyramid structure already established in the educational world, and offering a health education specialist as a 'vertical health-link' accessible to every horizontal need throughout the structure. To clarify this suggestion, the apex of the pyramid comprises the sixth form, 'A' level pupil, whether in grammar or comprehensive school, and proceeds downwards through secondary schools, through each secondary school's feeder schools, to the basal layer which will in part be common to several school pyramids—i.e. everyone caring in any way for the pre-school child. Amongst these I mention parents, fosterparents, child-minders, baby and toddler creches of various sorts, playgroups and nursery schools; also child health clinics. As in any structure, this foundation layer is vital to the well-being of each individual in each pyramid. The common unity of this foundation layer should prove of considerable strength to each pyramid rising up from it; anything disruptive of wholeness, will damage, even wreck, the worthiest endeavour. This vertical link of health education specialist is fundamental to the accurate understanding, and teaching, of health material. The link will best be accomplished by close co-operation with teachers, so that any health material to be handled in any piece of work at any level in the pyramid can be discussed with the health specialist. If it appears that actual involvement of the health personnel with the pupils would benefit the situation, that could easily ensue, and a relationship between the pupils and the member of the health team appropriate to the situation then develop as a continuing link throughout their school life. Health material arises naturally in many areas of everyday 'schooling', and the most comfortable, the least disturbing and dis-orientating, handling of it is surely to

'Feeder schools'—are those primary schools within the catchment area of a secondary school and from whence this school obtains its pupils.

'Vertical health-link' is the person responsible for the co-ordination of health education throughout the catchment area of the secondary school.

let it arise where it can. But the teacher, untrained in health material to adequate depth, and not geared to thinking that way anyhow, is not likely to recognise these opportunities, nor be able to take them up if he does, without help from a health-trained specialist. To me it appears preferable for this 'vertical health-link' to be incorporated into an educational pyramid throughout, rather than have a health education specialist at the apex, unco-ordinated flounderings in the middle, and at the base some health-trained health-orientated personnel who could provide the vertical link, but have not yet had that organised opportunity. At present, most apex situations have little specialist help and what is available is rarely co-ordinated.

To make this proposal work, it must first be decided who the vertical links are to be, and then how the network of horizontal contact can be made.

The first decision cannot be made without taking into account the depth of health material and understanding to be aimed at. For instance, there are not many schools who do not at some stage 'do a project on milk'. In my opinion, no such study would be complete without taking up at least some of the health material that arises naturally from the study of milk. Examples would be: the understanding of immunisation, herd and human; the present disease risks, brucellosis, bovine ringworm, anthrax and the like; milk yield in the context of reproductive function; mothering and relationship between mother and young; animal manipulation for human benefit. A little imaginative application will reveal much more health material which ought to be allowed to arise naturally when a project on milk is undertaken. The depth at which a facet is examined will be limited by the age of the pupil and/or the aim of the exercise, it ought never to be limited by the health knowledge of the teacher. Such information should be readily available from the 'health link' in depth and detail, and should be asked for, and discussed, in the preparation period of the work. In the examples discussed above, a doctor of medicine, a veterinary surgeon, a health visitor, a social worker and a health inspector could all be involved at some place, but which of these people could best deal with all these questions and who would most readily see what extra specialist help is required, and how to get it? Perhaps an educationalist will protest that he knows whom he needs to ask for help. In my experience in health matters, this is not so. I remember a young master who listened to me in growing astonishment, and then told me he had no idea a medical officer of health had any duties other than those relating to the health of the school child. Similarly, it seems a common misunderstanding to evaluate a health visitor on a lower rung of the nursing ladder, like an assistant clinic nurse, scarcely more knowledgeable than a school matron, who has no nursing training. Very worthy as these valuable auxiliary helpers are, it really needs to be understood that all health visitors have been under full-time instruction for at least four years, usually five, and not infrequently for six or more full years, longer than most teachers. Nevertheless, a health visitor's training is not just a matter of length but of the type of training, essentially the care of individuals, and groups of the population, in sickness and in health, needing help in their problems and homemaking, so that healthy units may be the foundation of our

society. Their work involves preventive health measures related to people in their homes, as well as clinics. Health visitors' training does not cover diagnosis and treatment of disease in any depth; it is fully occupied with the care of people. On the other hand, a doctor of medicine is trained to understand the structure and function of the human body, in health, and in disease; to recognise, diagnose and treat in individual patients diseases and disfunctions of the whole person, and promote health in the environment; this latter includes preventing situations detrimental to good health. Another possibility for a 'vertical health-link' is the trained health education officer, of whom all too few are available. The first essential, then, is to decide which of these trained personnel should be established as the 'vertical health-link' most likely to meet the greatest need in school health education, and I believe this decision should be taken without reference to the present availability of such personnel. I myself am very much of the opinion that the greatest asset in this situation is a broad and practising understanding of local health needs. Whatever the decision, a period of experimental outwork will be required to establish the sort of health link needed in the education pyramid.

The arrangement of the horizontal network will depend upon the understanding of health need, for instance: I doubt if any one factor is of more practical value in our whole way of living than really adequate mothering of our youngest citizens. So many millions of pounds are spent, so many millions of hours are wasted in a near-futile endeavour to undo the damage done in babyhood, by inadequate mothering. Thus the really basal health need in our pyramid is the concept of 'tender loving care'. This is easy to say—and well nigh impossible to achieve amongst the present problem-parents. Fostering the attitude of loving care amongst pupils vertically up the school pyramid will be of great practical value, spread horizontally amongst all age and ability groups in various ways year after year. Surely no fosterparent or child-minder should be enrolled, no creche, playgroup or nursery personnel of any grade should be appointed without compulsory instruction in the fundamental principles of mothering, loving handling and training of children of the appropriate ages. Such workers need the opportunity of frequent contact with the health personnel who gave them this initial help—not as a minatory link, but as an encouragement and development in the well-doing.

Throughout the school pyramid, health information will be required constantly as situation after situation arises in the course of the every-day school programmes progressing throughout the year. Suggestions of how this material can be incorporated, and should be introduced are the content of my scheme work: 'A First Approach to Health Education', 'A Second Approach to Health Education', and 'A Presentation of Health Education for Secondary Schools'. A sample is included as an Addendum. (The detailed guidance notes for teachers have been omitted.) This scheme work consists of suggestions, only, of ways in which health material can arise naturally within normal school activity. The 'First Approach' centres around the theme 'Good Health for the World', and is worked out on the divisions: 'Good Health for Me,

for My Family, for My School, for My Town, for My Country and for Other Countries'. The whole, or whatever parts may be used, enable the student to work towards defining for himself the term good health. The examination of 'Good Health for Me' will be concerned not only with the physical good functioning of limbs, senses, internal organs and general well-being, but in relationship with the environment, not simply with the physical environment, but particularly with the inhabitants of it. How one learns to give and receive affection, to communicate and maintain communication, is a vital part of good health. This scheme work is in no sense a syllabus, and must not be approached as such. Nor can this material properly be used by educationists without the co-operation of health personnel. It is my common experience that education personnel, however interested they are in health education, do not recognise their ignorance of health material; this is very understandable. Medical personnel tend to be uncommunicative, and whatever may be the general idea, health material requires experienced understanding; it is not possible just to read it up out of books, like many academic subjects. It is precisely because human beings are individual people, and will not react identically, even in the near-identical circumstances of catching measles, that it is essential for those trained in the understanding of health and disease in people to co-operate with teachers while they handle health material. I sympathise intensely with teachers who react to my ideas with near-despair, for lack of time; but I would point out that in-service training courses already exist for most disciplines and should include health education.

'A Second Approach to Health Education' offers suggestions for health material to be incorporated in historical teaching situations studying from early man through the ages to health requirements of the future space age. Pupils can deduce from their investigations what are the essentials of healthy living now, by establishing the basic requirements for sustaining life then, not least of which might be the refusal to quarrel, since individuals, even small groups, alone in the wild generally perish.

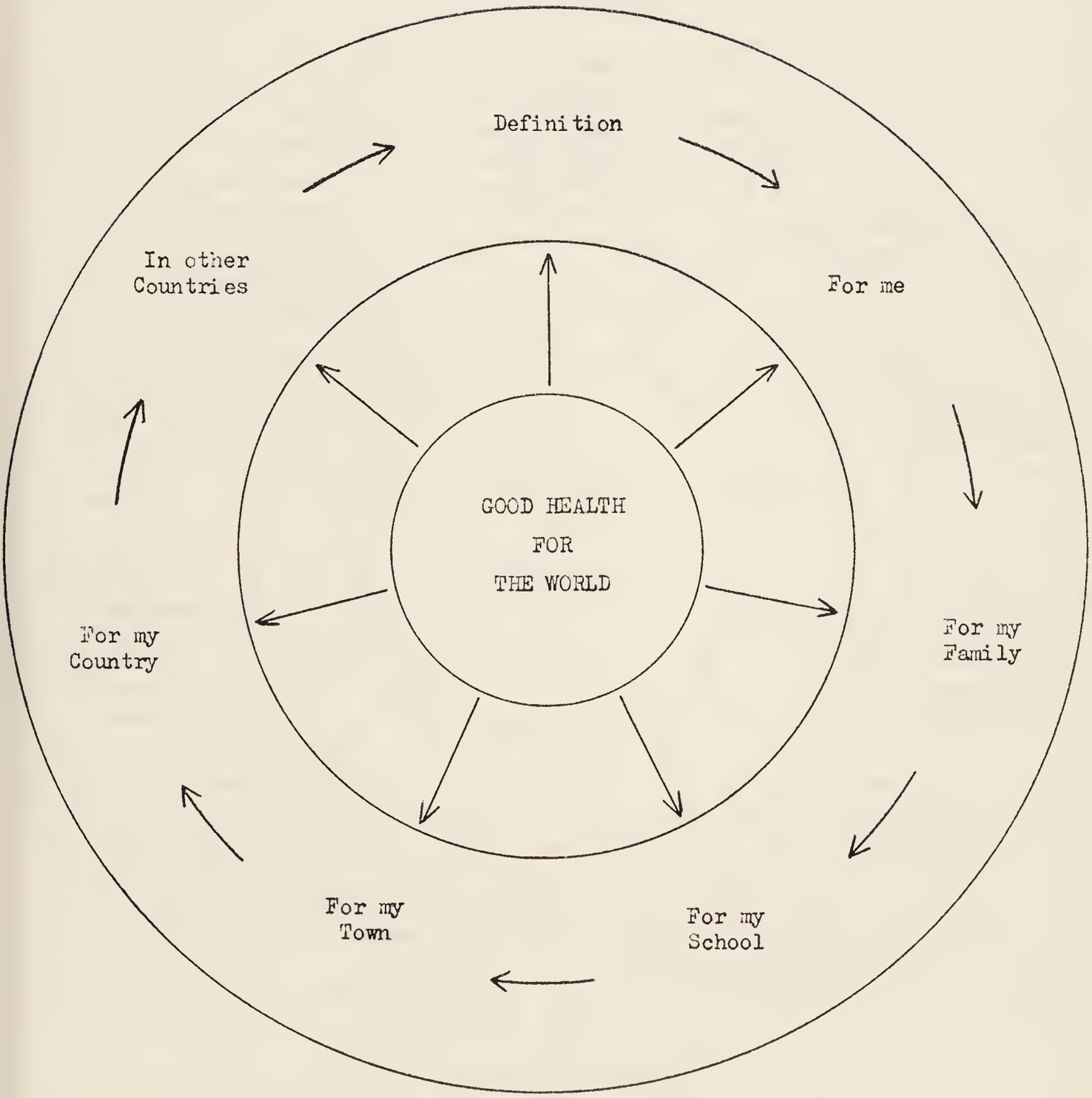
The third scheme, 'A Presentation of Health Education for Secondary Schools' is a rather different piece of work. Since it is assumed that pupils will have studied material in the previous two schemes, this work is aimed at helping pupils to take a square look at various situations to assess the actual health present and the improvement required. For instance, should one regard a thoroughly adjusted well-balanced physically handicapped person as healthy? If so, is there any responsibility for improving such a situation? Prevention is one such responsibility, environmental rearrangement, to improve for instance, the shopping and travelling circumstances for such individuals is another urgently necessary responsibility. And what about improving the general understanding of the man-in-the-street for the physically handicapped as another important requirement? This is all health education material, all part of the general health understanding without which our pupils should not be leaving school. Also, are persistent criminals to be regarded as healthy citizens. How did they become that way? Whether one considers these examples as more or less health education

than the difference between a bacterial and a viral infection, and the consequent differences in treatment, may be a matter of personal choice; to me, they are all essential material to be discussed with pupils in order that their future may be lived in deeper understanding, enjoyment and satisfaction. And it is by constant co-operation with health personnel, through frequent close contact with the 'vertical health-link', that teachers can be given the necessary health understanding and introduced to the member of the health team likely to be most helpful in any given teaching situation.

The 'vertical health-link' is the piece of machinery which now requires our attention. Schools will have individual preferences in approaching this manœuvre, and individual variations on a common theme are always interesting and useful. Still, the common theme is necessary to vary from. A practical dilemma arises because health personnel do not know enough about the work done in school to point out what health material could be included and where; and school staff members are not geared to thinking from a health point of view, and do not recognise opportunities which could be taken. How to get these mutual gaps bridged is the problem, and some means of closer discussion opportunity the solution. It might be possible for the 'vertical health-link' to attend certain staff meetings concerned with curriculum development, syllabus content, project work parties and the like, always bearing in mind that syllabus content, not school policy, is the 'health-link's' concern. There will be many doctors in the various specialities of the medical profession, who have particular interest in the history of medicine, others with medicine of the future such as living under water, or upon the surface of the moon. The 'vertical health-link' would be the one to make the contacts with such local talent as might be available, or gather together papers written, or recordings made, suitable for use in the school work. It is my experience that libraries are far more eager to help than we mostly are to seek their help, and I owe a considerable debt to the County Library in Wakefield for their assistance to me. Such closely co-operative effort in health education would be invaluable for the ongoing development of the whole community. The use of the already extant pyramid system should enable various levels in the pyramid not only to be aware of work at other levels, but consciously to build upon work basal to it, and prepare for the work to be done nearer the apex. When that is established, the whole school pyramid, with 'vertical health-link' should be well on the way to enabling each school leaver confidently to declare "My health in my hands", an aim worth working to fulfil.

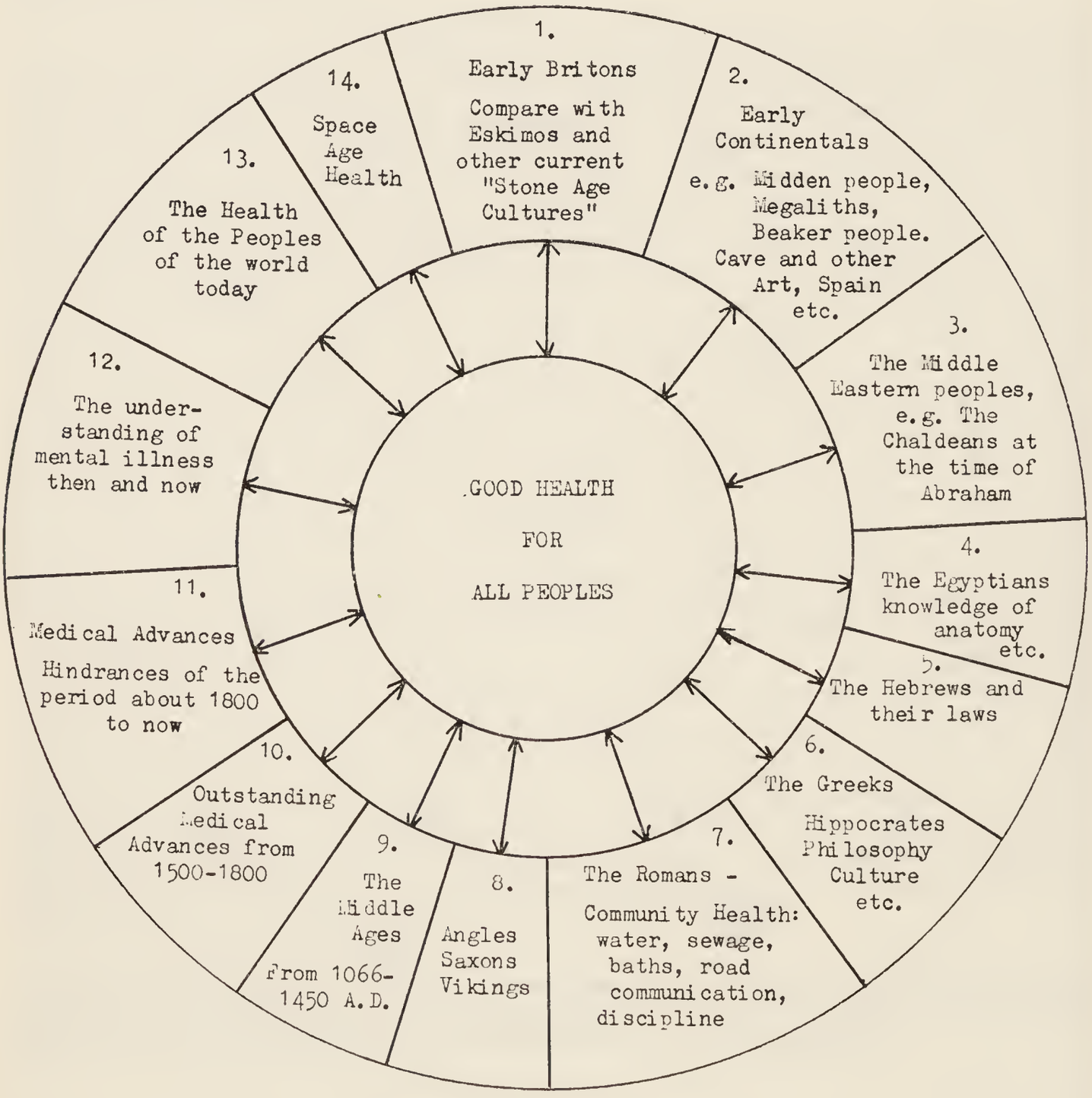
This is a personal account of Dr. Harvey's experience in two divisions in the West Riding. It should be read in conjunction with the report on health education on page 110 and especially to the work being undertaken by the Joint Working Party on Health Education.

A First Approach to Primary School Health Education



A Second Approach to Health Education in Junior Schools

Hub-and-Cover presentation of Health Education for Junior Schools.
Hub = Overall aim.
Circumference contains suggested manageable units covering the overall aim.



Thin Cover Costs Lives.

The hub contains the overall aim.

The circumference contains suggested exercise units covering this aim.
The exercises are not numbered in sequence of progression; they can be taken in any order.



POLLUTION OF THE ENVIRONMENT

D. Greenwood, Chief County Public Health Inspector

So much is written detailing the pollution of the environment that it is considered unnecessary in this essay to list all the various problems surrounding, or should it be submerging, us. Rather it is felt that a critical look at some parts of what we are doing, or in some instances, not doing, should be taken. With the current pressures of day to day work, do we do enough by way of forward planning and research to ensure that conditions tomorrow will be satisfactory? Do we spend sufficient money to monitor conditions today so that proof can be presented which will prevent unsatisfactory conditions tomorrow or at least enable us to obtain redress?

Atmospheric Pollution:

Constantly claims are made that industrial pollution has been brought under control but is it that in truth only the easier problems have been solved? Would the person smothered in cement dust in Northfleet feel satisfied with progress and do the inhabitants of the West Riding enjoy their views across the Dales being blotted out by lime burning or the delights of the local coke oven effluvia? If, as is reported, technology is capable of dealing with this pollution and the only problem is one of capital investment then why must we tolerate the situation? The argument whenever the spending of money is mentioned is that the cost of production would soar but apart from the fact of life that this is no novelty what price do we put on health and decent living conditions?

However, the blame for air pollution must not go to industry alone as domestic pollution is still a major problem. Whilst there is the odd authority in the West Riding which is completely smoke controlled the position runs right down the scale to the authorities where no start has been made at all. Whom do we blame for this, the Government for not giving us a national fuel policy, the elected member for not pursuing a policy of smoke control or the officer for not convincing his authority of the need for such measures?

Mention must also be made of pollution from motor vehicles which is an ever growing problem. One only has to sit in snarled up city centre traffic or be forced to follow a slow moving, badly maintained, lorry up a hill to appreciate this problem.

But what are we doing about air pollution and what can we do in future? The majority of the more difficult industrial processes is supervised by the Alkali Inspectorate and often their policy is criticised for being educative and persuasive rather than punitive. I believe in many instances they could and should take a tougher line. I also think that local authorities should co-operate with them more fully and bring the Alkali Inspector into consultations at the earliest possible planning stage of any project in which he is likely to be interested.

Local authorities must also ensure full co-operation between their own departments which too often in the past have operated in self-contained, and satisfied, units. One hopes that in the reorganised future far more exchanges of information and, if need be, officers will take place. The proposed county councils must continue the active participation in the field of air pollution control which they have shown for so many years. Opportunities will still exist for the co-ordinating role of the county council and one hopes to see strong future links with the medical staff of the new area health boards.

The need for more research is stressed in the *First Report of the Royal Commission on Environmental Pollution*[1] and as a step in the right direction the monitoring of air pollution must be put to useful purpose. By co-operation between the Planning and Health Departments of the County Council a pollution map of the West Riding has been drawn up. With further monitoring points it could become possible to show where housing development should or should not take place. As a further development of this could we not also use this knowledge to say "No" to further industrial development in certain areas where it was considered that pollution was already at saturation point?

The saving grace with domestic air pollution seems to be that whilst authorities vacillate, housewives slowly but surely change over to the piped fuels in their homes for convenience sake. One can only hope that in the new enlarged authorities progress will swiftly be made to resolve the remaining problems.

An enormous amount of research on pollution by motor vehicles has been and is still going on both by industry and government departments. Lead, one of the major pollutants, could be removed from our petrol without delay. We may, however, have to be content to pay more for our petrol and expect greater engine wear, unless a suitable alternative is developed.

Noise:

Why must we have to tolerate existing, for surely it cannot be regarded as living, next to major airports and engineers' masterpieces like Gravelly Hill motorway interchange? Why are factories built and then efforts made to suppress the noise after the complaints pour in from local residents? In so many instances the answer is forward planning, research, the monitoring of noise levels and more co-operation between all interested parties. In areas zoned for industry we must have the present background noise levels and be in a position to calculate the additional load by having full details of the buildings to be constructed and noise levels of plant and machinery to be installed.

With regard to motorway noise it has been interesting to see that by forward thinking Birmingham has obtained noise levels before and after the opening of the Gravelly Hill interchange. This has not yet eased the position of people having to live under intolerable conditions but it is a step in the right direction. At least the authority has evidence of the conditions to put before the Department of the Environment.

What about making more effort to stop vehicular noise at source however? Is the present legislation enforced by the police authorities sufficient? With the ever increasing demands on police time this duty could well be transferred to the attention of local authorities. New vehicles in Britain are subject to decibel standards but the limits are regarded as too high to effect the situation materially. Stiffer standards must be pressed for and public support gained towards this goal.

The First Report of the Royal Commission mentions how noise from aircraft is causing even more public disquiet than noise from transport. Although new types of engines are quieter than previous ones do we gain any advantage if the volume of air traffic continues to expand at the present high rate? Added to the future problem is the coming of supersonic flight. Aircraft noise and the siting of airports has engendered enormous public interest and indeed protest. Surely this is right that people should be interested in the quality of living standards and health authorities must be ready to supply factual evidence of noise levels to enable future decisions to be made.

Solid Waste:

Fancy packaging, non-returnable containers of all descriptions and materials, mattresses in the hedgerows, are but a few of the items to be disposed of by local authorities. The volume of domestic waste rises continually whilst in most areas land for controlled tipping becomes scarcer. Not that the waste is greater than the capacity of the holes in the ground but because the two rarely seem to be in the same place and the economics of the exercise rule against it. If we think of the dereliction of land as a pollution factor, and surely in the West Riding we must when it is being created faster than it is being reclaimed, then efforts must be made to use waste disposal as a means of land reclamation.

In the past far too little has been spent on refuse disposal in many areas and it must be realised that if we want to see our tips really controlled and if need be our waste reduced by incineration or pulverisation then we cannot continue to have this service on the cheap. When reorganisation takes place and the duty of refuse disposal comes to the metropolitan county councils it will be a splendid opportunity for a wider view to be taken of the problem of waste disposal and to include not only domestic but industrial and trade waste too.

Far tighter control must be exercised over the disposal of industrial and trade wastes. The careless and in some cases criminal negligence which has been seen in the disposal of toxic and dangerous wastes of late pin-points this necessity. The *Second Report of the Royal Commission on Environmental Pollution*[2] points out that almost all toxic solid wastes are disposed of by tipping and that the practice of disposing of toxic liquid wastes on land tips is growing rapidly. The Government is giving us specific legislation to deal with these problems in addition to existing powers under planning and public health laws. The problem will be of major public health significance in the new top-tier authority and the new legislation must be used to its fullest extent.

It is also plain from the above that local authorities in dealing with waste disposal, as indeed with the other subjects so far covered, must have inter-disciplinary teams of officers. The operation of such a service is going to need the skills of engineers, planners, geologists, chemists and health officials who must work together. Operational research will be a major task of the new authorities.

Water and Sewage:

Constant scrutiny must be maintained if this nation's enviable record of safe public water supplies is to be kept. With the ever-increasing demand for water it is now being taken from places which would never have been considered in the past. One ponders, with some river water, as to how many bodies it goes through before reaching the sea!

Whilst appreciating the high standards attained by the various water authorities and the expertise of their officers, public health officials must not lose sight of their own responsibilities to the general public and the help they can give to the water authorities. With the wide knowledge they have of the possible dangers in their own districts from sewage and other liquid effluents, from solid, including toxic, wastes, from chemical wastes and from the use of pesticides and herbicides they must ensure that swift lines of communication exist between the water authorities and themselves.

Local authorities themselves must also be prepared to spend more on sewage treatment works. So many authorities are turning out thoroughly unsatisfactory effluents and in some areas building development has been stopped because of grossly overloaded works. One wonders whether the poor record of so many authorities in this field is partly behind Government thinking in the proposed setting up of Regional Water Authorities. The Department of the Environment has said that the Government is prepared to spend £600 million on sewage treatment to bring the effluent up to acceptable standards. It should be done without delay.

Food:

Pesticides and insecticides in our food and antibiotics in the milk supply are acknowledged hazards. These too can be called pollutants but it is pleasing to write that in the main the safety of foodstuffs in this country is good. In a nationwide scheme of sampling of foodstuffs for pesticide content some two to three years ago excellent results were obtained and since that time even tighter restrictions on their use have been introduced. A recent *British Medical Journal*[3] article reported that clearly there is a downward trend of organochlorine pesticides residues in body fat.

The duty of sampling under the Food and Drugs Act in the proposed metropolitan counties will be with the county council and the opportunity must be taken to achieve a high level of uniformity of action and avoidance of the duplication of effort sometimes seen in the past. The technicalities of food

production and processing are becoming so complex that only a large authority will be capable of employing people with the necessary skills. The backing of a first-class analyst's department, operating as part of the county council service, must be obtained.

This service must also be available to the county districts who will have complementary duties in the food safety field. Strong links must be forged between the two authorities and indeed also with the medical staff of the proposed area health authorities.

The monitoring of food for lead and other heavy metals is being carried out at Government level and the Minister of Agriculture, Fisheries and Food has recently stated that present levels of lead shows no evidence of harm to health.

Only vigilance by all interested parties maintains a situation like this, however, and a watch must be kept for the next proposed chemical pollutant.

General:

Having mentioned in detail some of the major pollution problems affecting public health, I feel I must also remark finally on one or two minor matters affecting our countryside. The lady who telephoned me yesterday about roadmen spraying weeds in the verges and asking if it would kill her bees would be unlikely to agree that this was a minor problem to her; obviously that care must be taken to ensure that what is progress in one direction must not create dangerous conditions in another.

As travelling by car has increased so has the misuse of lay-bys and other stopping places as sanitary conveniences. The efforts made in the West Riding by way of the advanced signs for conveniences on trunk roads has made a marked improvement. One looks forward to seeing further provision of picnic areas complete with conveniences, water supplies and receptacles for litter. As a nation we seem to take a delight in leaving our rubbish wherever we go.

The amount of rubbish left by the itinerent traveller (I believe gypsies object to them being called gypsies) is another matter for concern. I am convinced that even if authorities do not wish to provide caravan sites and amenities for these people as a social exercise to eventually integrate them into the community, then they must still do so to prevent the spoiling of so many of our country areas.

Conclusion:

I hope that the foregoing is not too dismal a tale and that the impression is not gained that little is being done to combat pollution. A great many people are striving for improvements with efforts which go quietly on year after year. Perhaps we should shout louder in future and more quickly gain the public support which helps so much. I trust that I have given the message that in the coming reorganised local government we must work harder, officer with officer, department with department and authority or organisation with the like. There must be a freely flowing interchange of thoughts, information, expertise and, in some cases, officers.

References:

1. *First Report of Royal Commission on Environmental Pollution*, Cmnd. 4585, H.M.S.O., 1971.

2. *Second Report of Royal Commission on Environmental Pollution*, Cmnd. 4894, H.M.S.O., 1972.

3. Abbot, D. C., Collins, G. B., Goulding, R. *Brit. med. J.* 1972, *2*, 553.

THE DENTAL HEALTH OF MONGOLS IN DAY SPECIAL SCHOOLS AND TRAINING CENTRES

Joyce Neden, Dental Specialist

A survey of oral manifestations of Down's Syndrome exhibited in 310 children and adults attending West Riding Day Special Schools and Adult Training Centres has been carried out by members of the West Riding Dental staff and the following are observations on their dental health, together with suggestions for improving the availability of dental treatment to pupils and trainees in particular and the handicapped population in general. This paper is likely to be published in full in a technical dental journal. However, the main findings are as follows:

(i) High incidence of malocclusion.
(ii) High incidence of high-arched palate.
(iii) High incidence of congenitally missing teeth.
(iv) High incidence of increased salivation.
(v) High incidence of excessive calculus.
(vi) High incidence of poor oral hygiene and periodontal disease.
but a decreased caries incidence.

At the outset this survey was intended to supplement a similar one being carried out on mongols by the Health Department of the West Riding and to confirm or otherwise certain features, e.g. increased salivation, high-arched palate etc., which have come to be associated with mongols. It seemed opportune to combine this with an enquiry into their general dental health and to discover how much dental treatment had been carried out and to what extent this fell short of the desirable. These observations can only strictly be applied to that section of the mongol population attending day special schools and training centres but there is reason to believe that the dental condition of other mentally handicapped persons is not greatly better.

The treatment level in all age groups is appallingly low. Only a few of those inspected had well-cared-for mouths and these were mainly from the higher social groups and attended schools or centres in areas where the dentist/population ratio was favourable. In addition to that provided by the local authority, mostly for the pupils of the day schools, some treatment is provided for this group by general dental practitioners in the National Health Service. However, handicapped children usually take considerably longer to treat than normal children and it is not to be expected that dentists working on an item of service basis of remuneration are likely to accept responsibility for more than a limited number of such cases. It is necessary, therefore, that treatment of these patients be carried out within the framework of a salaried service and it is estimated that it will require the equivalent of one full-time dental officer to treat the 700 known mongols in the West Riding and if, in addition, all the mentally and physically handicapped persons to whom we have a responsibility are to be treated, it is reasonable to assume that more dental officers than can at present be made available would be required.

Many mongols have speech, hearing and heart defects, respiratory infections are common and a percentage would require hospitalisation, particularly for extraction of teeth. The lower incidence of dental caries found in mongols, however, encourages one to conserve teeth, particularly since in many cases they are intolerant of dentures. Poor oral hygiene clearly presents as a factor in the progression of periodontal disease but with co-operation of parents and school staff, oral hygiene could be substantially improved. Dental health campaigns in day special schools and training centres should be flourishing—most of these establishments have good staff-student-parent relationships and frequent after-hours functions, when dental health could be discussed and planned as a team effort. In the course of the survey, the frequency of requests made by parents and staff alike to arrange treatment for the children and trainees, indicates a lack of liaison at present existing between the dental service and these establishments.

Certainly not all mongols can be treated completely successfully but they should be offered at least the same facility for treatment as that offered to the general population. Much of the responsibility for ensuring that these people attend for treatment has in the past fallen to members of the school staffs or welfare workers and in many cases they, not the parents, have been the ones to accompany the children for treatment at clinics.

Many mongols are the children of elderly parents and some of the older ones are orphans and cared for frequently by distant relatives, many of whom are working and, with the best will in the world, place dental treatment very low on the list of necessities. Most mongol persons travel some distance by bus from home to centre every day and it is often the case that either the parent, guardian or child has difficulty in reaching the clinic specific to that area unless the child is absent from school for a complete day, which it seems these children are loathe to be. There should therefore be some interchange of patients between clinics so that children or parents are able to attend the one most convenient to them.

There is a large number of mentally handicapped persons over the age of 15 years who do not attend any form of centre, either occupational or therapeutic, and, by virtue of their homes being scattered throughout the West Riding, are most inaccessible. Treatment can be provided for this group only at the direct request of a parent or welfare worker. It would seem reasonable, therefore, to inspect and treat the accessible younger age group in day special schools regularly on a six monthly recall system and that this contact be maintained in later life, irrespective of whether they attend a training centre or not.

As from the 1st April, 1971, the responsibility for children in day special schools lies specifically with the School Dental Service. This being so, children in these schools should be inspected and treated at least as regularly as children in normal schools. Clearly, provided school clinics are fully staffed and there are adequate dental practitioners in the area, the handicapped children will be inspected and treated regularly.

PART I

VITAL STATISTICS

EPIDEMIOLOGY

VENEREAL DISEASE

RESEARCH

See also Tables 1 to 34 of Appendix A

VITAL STATISTICS

Area and Population:

	Municipal Boroughs and Urban Districts	Rural Districts	Administrative County
Area (acres)	380,315	1,226,148	1,606,463
Population:			
Census, 1971 ...	1,271,869	520,151	1,792,020
Estimated (mid-1971)	1,277,180	524,380	1,801,560

Number of Municipal Boroughs, 13; Urban Districts, 55; Rural Districts, 21; Total 89.

Summary for 1971:

	Administrative County	England and Wales
Live Births		
Number	30,687	
Rate per 1,000 population	17·0	16·0
Illegitimate Live Births		
Number	2,122	
Per cent. of total live births	6·9	8·4
Stillbirths		
Number	382	
Rate per 1,000 total live and still births	12·3	12·5
Total Live and Still Births...	31,069	
Deaths: All causes	20,585	
Rate per 1,000 population	11·4	11·6
Infant Deaths (deaths under 1 year)	566	
Infant Mortality Rates		
Total infant deaths per 1,000 total live births ...	18·4	17·5
Legitimate infant deaths per 1,000 legitimate live births	17·8	16·9
Illegitimate infant deaths per 1,000 illegitimate live births	26·9	24·1
Neonatal Mortality Rate (deaths under 4 weeks per 1,000 total live births)	11·0	11·6
Early Neonatal Mortality Rate (deaths under 1 week per 1,000 total live births)	9·5	9·9
Perinatal Mortality Rate (stillbirths and deaths under 1 week combined per 1,000 total live and still births) ...	21·7	22·3
Maternal Mortality (including abortion)		
Number of deaths	3	
Rate per 1,000 total live and still births	0·10	0·17

Live Births:

Apart from the slight interruption in 1970, since 1964 the crude birth rate has pursued a downward trend. There were 30,687 births registered, equivalent to a rate of 17·0 per 1,000 population compared with a rate of 17·3 in 1970 and an annual average of 17·6 in the years 1966 to 1970. It would appear that the decrease in the rate will continue through to 1972 with the rate of decline less marked. The County rate was again appreciably higher than that for England and Wales (16·0).

The birth rate adjusted for variations in the age/sex structure of the population for the aggregates of Municipal Boroughs and Urban Districts was 17·2, for Rural Districts 16·9, and the Administrative County 17·2.

The number of extra-marital births was 2,122, 39 fewer than in the previous year, but representing 6·9 per cent. of total live births, the second highest level recorded since 1945. The rate, however, continues to be lower than national (8·4 per cent.).

Stillbirths and Infant Mortality:

STILLBIRTHS:

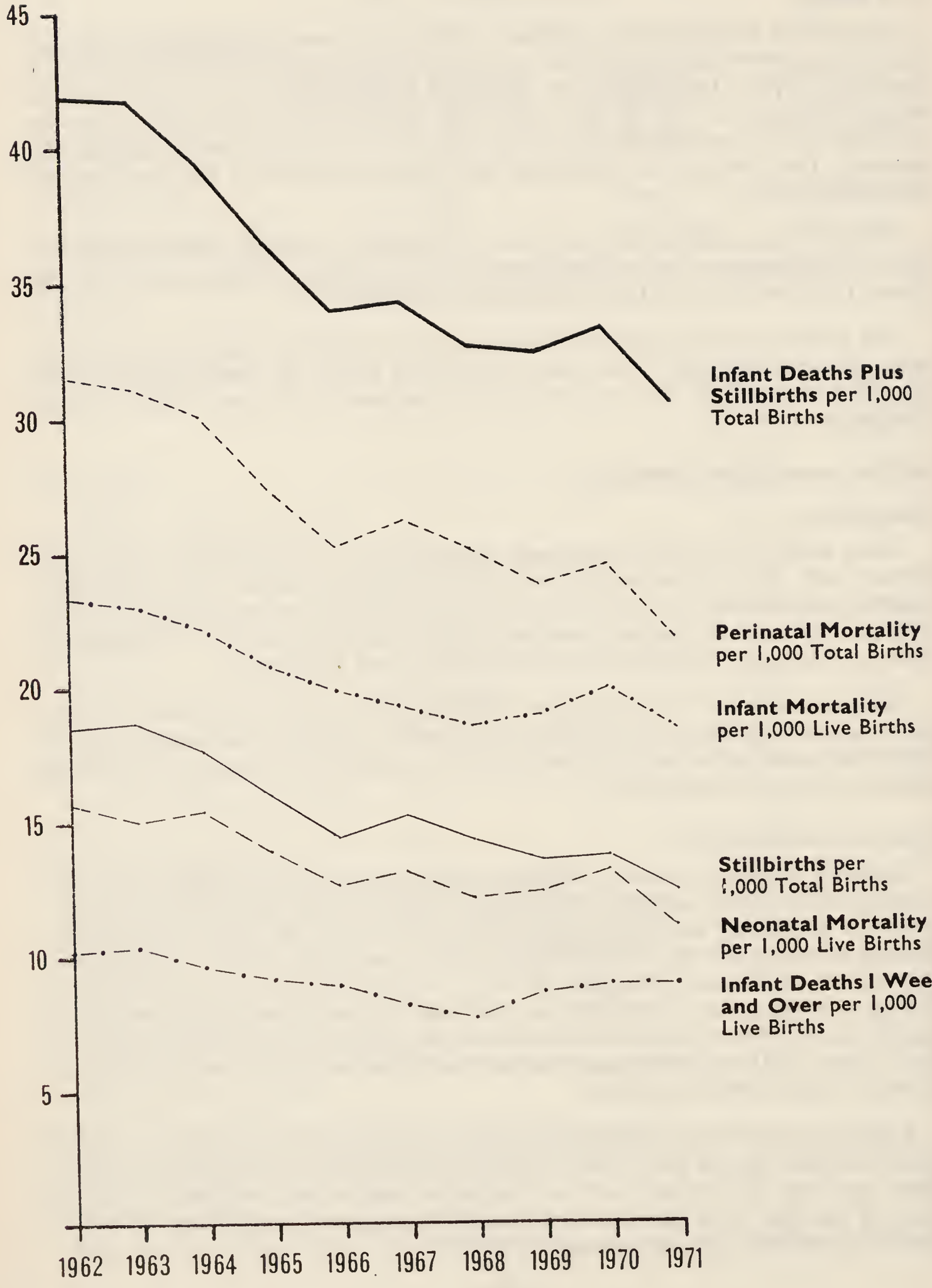
There were 382 stillbirths registered, representing a rate of 12·3 per 1,000 total births; both the number and the rate are the lowest recorded. During the past quarter of a century there has been an irregular decline in the rate nationally as well as locally and for the first time the County rate is below that of England and Wales. Of the total stillbirths 39 (10·2 per cent.) were illegitimate.

The operation of the Population (Statistics) Act, 1960, has enabled more information regarding each stillbirth to be made available; the number of stillbirths allocated to the various causes and the corresponding rates per 1,000 total births are given in Appendix A.

PERINATAL MORTALITY:

Perinatal mortality, which comprises stillbirths and infant deaths in the first week of life, provides an index of the loss of infant life due to conditions associated with pregnancy and the events during labour and delivery. Since records became available for the Administrative County, apart from minor fluctuations, the rate has significantly declined. In 1971 a new low level of 21·7 was achieved, 2·7 per 1,000 less than in the previous year and 0·6 lower than the national average. Both causes contributed to the decrease, the stillbirth rate declined from 13·6 to 12·3 per 1,000 total births and the rate for deaths in the first week of life from 10·9 to 9·5 (per 1,000 live births).

Although contributing less than in previous years, prematurity with its multifarious origins was the prime cause with 204 (70 per cent.) of the infant deaths at these ages and 221 (58 per cent.) of stillbirths had a birth weight of 5½lb. or less. Of the first week deaths associated with prematurity, 130 died within 24 hours of birth and 27 in the second day of life.


45
40
35
30
25
20
15
10
5
1962
1963
1964
1965
1966
1967
1968
1969
1970
1971
Infant Deaths Plus Stillbirths per 1,000 Total Births
Perinatal Mortality per 1,000 Total Births
Infant Mortality per 1,000 Live Births
Stillbirths per 1,000 Total Births
Neonatal Mortality per 1,000 Live Births
Infant Deaths 1 Week and Over per 1,000 Live Births

Infant Mortality:

Since 1947 the rate has halved and, apart from minor interruptions, has pursued a downward trend. In 1971 the steady decline was maintained to reach a new low record of 18·4 per 1,000 live births.

The major gain was in the neonatal period with the number of deaths decreasing from 409 in 1970, to 338. First day deaths were 34 fewer than in the previous year, deaths at ages 1-6 days 13 less, and at ages 1-4 weeks 24 less. Mortality from anoxic and hypoxic conditions fell from 131 to 97 and, as mentioned previously, the involvement of prematurity was less pronounced and was incriminated in 18 fewer deaths.

The improvement in the neonatal period was to some extent offset by an increase in later months; the number of deaths increased by 23, mainly in the three months up to one year age group. Pneumonia and other respiratory diseases were largely responsible and to a lesser extent violence.

In spite of the reduction in loss of infant life the County rate continues to be higher than the national rate and that for certain other countries; clearly gains must be achieved before an irreducible minimum is reached.

Illustrated graphically are the trends of the rates associated with loss of fœtal and infant life during the past ten years.

Deaths:

After three years of relatively high mortality and the crude death rate appearing to be in an upward trend, it is satisfactory that both the number of deaths and the corresponding crude death rate declined. There were 20,585 deaths representing a rate of 11·4 per thousand population compared with a rate of 11·7 in 1970, and a national rate of 11·6 (11·7). The crude death rates adjusted by the comparability factors were, for the aggregates of Municipal Boroughs and Urban Districts, 12·5, Rural Districts 12·1, and the Administrative County 12·3.

Table 9 of Appendix A gives the deaths by age and major cause group. The proportion of deaths ascribed to the principal causes conformed to established trends, the percentage contributions to total mortality were as follows: heart and circulatory disease (excluding cerebrovascular disease) 38·6 of total deaths (37·9 in 1970), malignant neoplasms 18·9 (18·3), cerebrovascular disease 15·3 (14·9), respiratory diseases 12·5 (14·4) and violent causes 4·1 (4·1).

The foregoing represents the contribution to the total mortality by the major causes of death, but in economic terms the relative frequency of certain causes assumes greater importance. Whereas over 70 per cent. of the deaths occurred at ages 65 years and over, mortality at ages 15-64 years caused a loss of over 60,000 working years which might have been available before retiring age. Of this premature loss of working life cerebrovascular diseases accounted for 6 per cent. of the total, other circulatory diseases 30 per cent., malignant neoplasms 26 per cent. and violent causes 18 per cent.

With cardiovascular disease, mainly arteriosclerotic heart disease, and vascular lesions affecting the central nervous system contributing over half the total mortality the involvement of the self-inflicted hazards of cigarette smoking, obesity and lack of exercise emphasises the need for individual decision and corporate health education action. Cardiovascular disease, as well as being the major cause of death in highly developed countries, is now increasing the burden of disability and suffering in developing areas of the world, and this has been recognised by declaring the theme of World Health Day for 1972 to be the prevention and treatment of the disease.

Nearly a fifth of all deaths were caused by malignant disease; mortality was again slightly more prevalent at ages 45-64 years than in previous years, otherwise there were only minor variations in the age/sex distribution.

Concern again must be expressed at the continued rise in male deaths from lung cancer; 973 died from this cause, once again the highest total registered and more than twice the level recorded two decades ago. This increased mortality is not peculiar to the West Riding, nor, indeed, to Britain, for in all countries from which reliable statistics are available, there has been a marked upward trend in recent years.

Pre-School Age (1-4 years):

In the quinquennium 1911-15 the annual average rate per 1,000 living in the age group was 17·13, by 1935-39 the rate had reduced to an annual average of 5·09 and in 1945-49 to 2·23. Since then the rate of decline has not been so dramatic and in 1965-69 the average rate was 0·82. In 1971 there were 65 deaths representing a rate of 0·53, the lowest recorded, compared with 88 deaths and a rate of 0·72 in 1970.

Virtual control of the once traditional childhood diseases has resulted in accidents, respiratory diseases, congenital malformations and cancers being the more prominent causes of death; in 1971 these causes were responsible for 69 per cent. of the mortality.

School Age (5-14 years):

The lowest death rates at any age are recorded for the group; however, further improvements could be achieved if fatalities from accidental causes, which are largely preventable, were eliminated. Deaths totalled 97, of which accidents accounted for 34 with boys most frequently the victims in the ratio of 3:1.

Mortality from congenital malformations (10), and the malignant neoplasms (16) remain around the same level as in recent years but it is significant that while leukaemia once made a minor contribution to total mortality, 11·5 per cent. of deaths in this age group were classified to this cause. The disease ranks second as a cause group of death at these ages.

ADOLESCENCE AND AFTER (15-24 years):

There have been only minimal variations in the causes of mortality during the past decade. In 1971 there were 186 deaths and while malignant neoplasms (19) and respiratory diseases (13) exacted their toll, deaths from violent causes predominated and accounted for 112 victims, or 60 per cent. of mortality in the age group; motor vehicle accidents were involved in 70 deaths and caused nearly a half of the total male mortality.

YOUNG ADULTS (25-34 years):

In the post-war period mortality in this group has maintained a gradual downward trend. The age/cause of death distribution followed the usual pattern with male deaths in excess in the ratio of 2:1. Of the 177 deaths, violence, notably motor vehicle accidents (33) and suicide (19), was the major cause, followed by malignant neoplasms (35) and diseases of the circulatory system (29).

ADULT (35-44 years):

While the general death rate remains low at these ages, some of the most frequent causes of total mortality gain prominence. Deaths totalled 441, 270 males and 171 females. Among males, ischaemic heart disease (78), violent causes (51), and lung cancer (16) were the principal causes and in females, cancer of the breast (25), violence (25), cerebrovascular disease (15), and ischaemic heart disease (14).

MIDDLE LIFE (45-64 years):

Of the 4,542 deaths registered in this 20 years life span the most numerous causes, in descending order, were ischaemic heart disease (1,412), malignant neoplasms (1,385), cerebrovascular disease (384), bronchitis (234), and violence (192).

Mortality from ischaemic heart disease pursued an upward trend, especially in males; more than one third of male deaths were from this cause. Of the cancer deaths, the predominant site was lung and bronchus in males (1 in 9 male deaths in this age group), and in females, malignancies in the breast and uterus.

OLDER AGES (65 years and over):

As mentioned previously, 70 per cent. of the total mortality was at these ages. In all there were 14,511 deaths with the patterns of mortality obtaining in middle life being broadly continued at these older ages with the degenerative diseases predominating. As age advanced excess male mortality became less pronounced and at ages 75 years and over female deaths were in the majority.

EPIDEMIOLOGY

Incidence and Notification of Infectious Disease:

The tables in Appendix A provide a summary of the age and sex distribution of cases notified during 1971 and where applicable, a comparison is given of the notifications in the five preceding years.

ANTHRAX:

From 1960, when the disease in humans became notifiable, to 1966, a total of eight cases has been notified in the Administrative County, since when no case has been reported. The vaccination of workers considered to be particularly exposed to the risk of contracting the disease has continued.

DIPHTHERIA:

No case has been reported since 1964. Although the national incidence still remains low occasional flare-ups and imported cases serve as a reminder of the importance of achieving and maintaining the optimum level of protection of our child population by immunisation.

DYSENTERY:

Incidence varies from year to year with no discernible trend. There were 538 cases originally notified which on revision of diagnosis was reduced to 406 compared with 287 in 1970 and an annual average of 488 during the period 1966-1970.

Seasonally, incidence was higher during the first half of the year with an outbreak at Thurcroft comprising 74 cases occurring in the second quarter. Reporting on the outbreak, Dr. Clow, Medical Officer of Health, Rotherham R.D., wrote:

> "There is an outbreak of sonne dysentery in the Thurcroft area. The first notification I had was on 29th March, and the number of cases in the last five weeks has been about 70. However, during the last few days, the number of notifications has only been four and I am hopeful that the outbreak is on the wane.
>
> The source of the infection is very difficult to isolate, as in all sonne outbreaks. Thurcroft is a very closely knit community; people tend to visit the same welfare clubs, public houses etc., and the children of several families are very often closely linked by intermarriage within the community.
>
> I have personally visited the schools in the area and discussed questions on hygiene with the headteachers. We have distributed various propaganda, posters etc. to these schools and are exhibiting them at the clinic, emphasising personal hygiene and food preparation. The local general practitioners are coping quite satisfactorily with the cases and as far as I am aware, no-one has been particularly ill."

ENCEPHALITIS:

Cases of the disease are classified as 'post-infectious' if associated with or following infectious disease or smallpox vaccination; in cases where no such

relationship is established the classification of 'infective' applies. In 1971 no case of either category was reported.

ENTERIC FEVERS:

Typhoid Fever:

In 1941 typhoid and paratyphoid fevers became separate entities for notification purposes; since that time the annual number of notifications of typhoid have varied within the range of nil to 27. There were no cases in 1971.

West Riding school parties holidaying in areas of relatively high incidence such as the Mediterranean continue to be advised to be adequately vaccinated against typhoid and paratyphoid fevers. It is also impressed on the parties and their organisers that vaccination does not supplant the need for high standards of hygiene. These instructions were issued some years ago and that no incidents have arisen underlines the effectiveness of these precautionary measures.

Paratyphoid Fever:

Two cases were confirmed. A blood culture from a 36 year old woman who had her gall bladder removed revealed *Salm. paratyphi B* phage type 3a1. There were no secondary cases. The other notification was of a male Pakistani who went to Pakistan in March, having been inoculated with T.A.B. during the preceding January and February. He returned to this country in July and visited various places before proceeding to his usual place of residence. Shortly after arrival home he fell ill and was subsequently admitted to hospital where *Salm. paratyphoid A* was confirmed in a blood culture. All contacts at home and at the places he had visited were negative. There appears to be no doubt that the infection was acquired in Pakistan.

FOOD POISONING:

There were 126 incidents reported (114 notified cases and 12 ascertained) compared with 165 in 1969 and an annual average of 164 in the years 1965-69. In the table below the major microbial causes are analysed by type of incident.

Presumed Causal Agent	Family Outbreaks		Other Outbreaks		Sporadic Cases	Total Cases
	Number	Cases Involved	Number	Cases Involved		
Salmonella typhimurium	7	20	1	4	22	46
Other Salmonellæ ...	9	23	1	5	30	58
Cl. welchii	—	—	—	—	2	2
Staph. aureus	—	—	—	—	—	—
Not discovered	3	8	—	—	12	20
All agents	19	51	2	9	66	126

In addition there were 57 cases of salmonella infection not food-borne.

In recent years there has been a decline in the incidence of *S. typhimurium* within the total picture of salmonella food poisoning. In 1971, however, the organism was responsible for 36·5 per cent. of incidents.

Four cases of *S. typhimurium* formed part of a wider outbreak. At a wedding reception held in the Administrative County some 60-70 guests were at risk and many were infected in varying degrees. The source of infection was traced to a chicken salad and on further investigation a member of the catering staff was found to be a carrier.

The origin of an outbreak of five cases of *S. indiana* was traced to roast pork from a local butcher's shop: samples of the product at the shop also showed a heavy growth of the organism. Fæcal specimens from six assistants were positive for *S. indiana* and they were excluded from work until three consecutive negative specimens were obtained.

The pre-cooking of food, especially meat and meat products, followed by imperfect cooling and storage creates an unnecessary risk of food poisoning. The disease could be virtually eliminated by strict adherence to a rigid code of kitchen hygiene and practice supplemented by clean food handling.

INFECTIVE JAUNDICE:

Reported incidence was lower than in the two preceding years; a total of 589 notifications was made of which 297 related to children in the 5-14 years age group. Seasonally, notifications were most frequent in the period January to April.

Commenting on an outbreak in a hospital for the subnormal, Dr. Lowe, Medical Officer of Health for Goole R.D. wrote:

> "On 18th October, 1971, a girl, aged 10 years, in a unit for severely subnormal children was taken ill with vomiting, abdominal pain, loss of appetite, accompanied by fever. Two days later jaundice appeared and the liver became slightly enlarged and tender. By the 20th October, five more cases had occurred with similar symptoms. The severity of the disease varied but in most cases was mild and the children soon recovered. Stools were pale and the urine dark in all cases.
>
> Blood was taken from these six cases for liver function tests and to exclude serum hepatitis; all were negative for H-A antigen and so the diagnosis of serum hepatitis was unlikely. Liver function tests showed mild to moderate elevation of the transaminase levels and in four cases mildly elevated bilirubin levels.
>
> One case of hepatitis occurred on 28th October, in a day patient, two more cases on 5th November, and a further two cases on 11th November, thus making 11 cases in all, out of 25 children. None of these children had taken any drugs likely to cause hepatitis.

The explosive nature of the outbreak presupposes a common contact; there was no history of any illness amongst staff or other patients.

All the staff of the unit and the remaining children were given a full dose of gammaglobulin; those children under 10 years received 250 mg. each, adults and those over 10 years were given 500 mg. each, including two subnormal adults who had been helping in the children's unit. No other cases occurred in the hospital."

Statutory notification of cases has enabled medical officers of health to investigate the epidemiology and incidence of the disease. There are many obscure features of both components of the disease and much more research at national and local level is necessary before the epidemiological complexities can be unravelled. In recent years there has been a case fatality rate nationally of around one per cent. which emphasises the urgency of the production of a virocidal agent and/or an effective vaccine.

INFLUENZA:

As the disease is not statutorily notifiable the most sensitive index of morbidity is the week to week variations of new claims to sickness benefit issued by local officers of the Department of Health and Social Security supplemented by information regarding school and industrial absentees.

In England and Wales both influenza A and B viruses were circulating over an extended period without causing a noticeable outbreak.

MEASLES:

Past experience was for measles to assume epidemic proportions during autumn through to spring biennially; in the period 1962 to 1968 however, this cycle was not in evidence and notifications ranged between 13,000 and 20,000 per annum. Low incidence in 1969, with highest prevalence during the first half of the year, suggested a return to the cyclic seasonal norm but the expected autumn peak was absent and an outbreak in the spring/summer of 1970 continued the irregularity.

In 1971 there were 4,869 notifications of which 2,851 (58·6 per cent.) occurred in March through to July. Of the total notifications 2,711 (55·7 per cent.) related to children under 5 years and 1,984 (40·7 per cent.) in the 5-9 years age group; there was a slight male excess at all ages.

Routine vaccination against measles is now generally an accepted procedure in a child's vaccination and immunisation programme. Even so, too few children have been vaccinated and if the disease is to be eradicated it is imperative that an extensive campaign be undertaken to secure the vaccination of all susceptible children.

A review of the Authority's participation in the Medical Research Council's trials of measles vaccines which preceded the introduction of the national scheme of vaccination appears on page 82.

Measles Vaccination:

The number of persons who received vaccination against measles during the year was as follows:

Born in Year	
1971	8
1970	10,598
1969	8,955
1968	1,672
1964-67	1,868
1955-63	119
Total	23,220

Rubella Vaccination:

By Department of Health and Social Security Circular 11/70 of the 29th July, 1970, Local Health Authorities and Authorities exercising delegated health and welfare functions were asked as a matter of public policy to make arrangements under the provisions of Section 26 of the *National Health Service Act, 1946,* to offer vaccination against rubella to girls between their eleventh and fourteenth birthdays but that initial priority should be given to those in their fourteenth year. The arrangements were to be brought into operation as soon as possible and general practitioners were to be invited to participate in the scheme and provided with the rubella vaccine they would require.

The Secretary of State recognised that the introduction of vaccination against rubella might cause unexpected additional expenditure by Local Authorities and for this reason he had decided to supply the vaccine required up to the 31st March, 1971, free of charge to enable Authorities to offer vaccination to all girls aged 13 years. Local Authorities would be required to purchase the vaccine required after the 31st March through normal commercial channels. Approval to the operation of the rubella vaccination scheme as from September, 1970, was given by the West Riding Health Committee. During the year 1971, 10,816 girls received vaccination.

MENINGITIS:

There was a total of 30 cases notified compared with 55 in 1970 and 48 in 1969. Acute meningitis is not a single disease entity and a breakdown in terms of the infecting micro-organism revealed that the meningococcus was incriminated in 17 cases (22 in 1970), other specific organisms 8 (11) and unspecified organisms 5 (22).

Of the total notifications 10 were of children under the age of 5 years and four in the 5-9 years age group. There was no focus of infection or apparent connection.

POLIOMYELITIS:

The County has been free from the disease for the past three years. Satisfactory progress towards elimination of the disease is being maintained with incidence and mortality remaining low nationally. The incentive to vaccinate children and persons at special risk must not be diminished if we are to prevent a recurrence of the disease.

Vaccination against Poliomyelitis:

At the year-end the total number of persons who have received protection against poliomyelitis in the County, taking into account both Salk and Oral vaccine, was 903,254.

SCARLET FEVER:

Notifications numbered 740 compared with 661 in 1970, and an annual average of 1,001 during the period 1966 to 1970. The seasonal distribution conformed to the usual pattern with incidence high in the first and fourth quarters. By far the majority of cases were mild and were nursed at home; no deaths were reported.

SMALLPOX:

No case has been notified since 1962. Changes in the prevalence of smallpox in countries overseas and the diminishing likelihood of the occurrence of outbreaks in this country prompted the Joint Committee on Vaccination and Immunisation to re-assess the balance of risk in the recommended schedule of vaccinations against the benefits derived.

The Joint Committee concluded that the number of serious risks arising out of vaccination in childhood was out of proportion to the risks of smallpox in this country and considered that vaccination against the disease need not now be recommended as a routine procedure in early childhood. Endorsing this conclusion the Secretary of State accepted the Joint Committee's advice that:

1. Vaccination against smallpox need not now be recommended as a routine in early childhood;
2. All travellers to and from areas of the world where smallpox is endemic or countries where eradication programmes are in progress should be protected by recent vaccination;
3. Health service staff who come into contact with patients should be offered vaccination and re-vaccination.

The above recommendations were implemented by the Authority and the vaccination and immunisation schedules amended accordingly.

TETANUS:

Notification of the disease was introduced in October, 1968, since when no case has been reported.

Tetanus Immunisation:

The total number of children who completed a primary course of protection against tetanus during 1971 was 28,635. A secondary or reinforcing injection was given to 30,628 children.

WHOOPING COUGH:

Reported incidence which reached a record low level in 1969 is now showing an upward trend. Increased prevalence during the last quarter of 1970 persisted through the first quarter when 523 (61·0 per cent.) of the total 857 notifications were made. Incidence diminished as the year progressed. The age/sex distribution followed the usual pattern with 12·1 per cent. of the notifications relating to infants under 1 year, 46·6 in the 1-4 years age group and 36·3 at the ages 5-9 years. Notifications were slightly more numerous among females at all ages.

This can be a distressing and potentially dangerous disease of early infancy; of the 104 notifications in the first year of life one was fatal. It is disappointing that in spite of the uptake in vaccination and the modification of the immunisation schedules to permit the vaccinations to be carried out later in a child's life when antibody response is improved, there should be this upward trend in notifications. Further research is necessary to add stimulus to the search for more effective vaccines.

Immunisation against Whooping Cough:

During the year 26,404 children completed a full course of immunisation against whooping cough and since facilities were introduced in 1952 a total of 361,092 have been immunised under the County scheme. The number of children in the 0-4 years age group was 94,516 representing 84·4 per cent. of the total population in this age group. Of the 837 notifications of whooping cough in the 0-14 years age group 327 concerned children who had been immunised.

VENEREAL AND SEXUALLY TRANSMISSIBLE DISEASES

In 1971 a new quarterly statistical return form was used at special clinics. In this improved form new cases of each sex were allocated into one of four groups, namely, syphilis, gonorrhœa, other genital infections and other conditions. Each of these four groups was then subdivided to provide further details.

Syphilis:

The number of new cases of all types of syphilis decreased by three to 38 of which nine were found to be suffering from the early infectious stage of the disease. For the seventh successive year there were no cases of congenital syphilis in infants under one year of age. Cases of syphilis comprised less than one per cent. of the total new cases.

Gonorrhœa:

The number of new cases was 647, an increase of 10 per cent. on the 1970 figures. Of 406 cases in males, 12 per cent. were under 20 years of age. Of 241 cases in females, 29 per cent, were under 20 years of age.

In previous reports attention has been drawn to the fact that the ratio of male/female cases is gradually approaching 1 : 1. By 1971 the ratio had come down to 1·7 : 1. More than 14 per cent. of all new patients had gonorrhœa.

Other Genital Infections:

This large group (45 per cent. of all new cases) included 12 different infections or infestations, all sexually transmissible. Four were common, four were less commonly found and four were rarely diagnosed.

The four common diseases were non-specific genital infection, candidiasis, trichomoniasis and genital warts. Thirty-nine per cent. of the total cases of other genital infections were in females. Of the 979 cases of non-specific genital infection 84 per cent. were males. On the other hand 86 per cent. of the cases of trichomoniasis were in females. One reason for this anomaly is that the trichomonas vaginalis, the microscopic parasite of this infestation, is difficult to recover from the male genito-urinary tract. It is probable that some cases of male trichomoniasis were misdiagnosed as non-specific genital infection. The four less commonly diagnosed conditions were scabies, pubic lice, genital herpes and Reiter's disease (non-specific genital infection with arthritis).

Other Conditions:

This group (almost 40 per cent. of the total new cases) included treponemal diseases other than syphilis (1 case), other conditions requiring treatment (420 cases) and conditions not requiring treatment in the clinic (1,338 cases). Most of the latter were babies for pre-adoption examination and blood tests, unmarried expectant mothers or uninfected individuals who had been exposed to possible infection with a venereal or sexually transmissible disease.

In reviewing the statistics of the last 10 years one sees that the number of West Riding Administrative County residents attending the 16 special clinics serving the area has more than doubled, and in 1971 was 4,448 cases. The increases have been confined to cases of gonorrhœa and other conditions, including sexually transmissible diseases. Fortunately, cases of syphilis have decreased in number by about 50 per cent. to only 38 in 1971. There is no complete explanation why this should have happened. With regard to the increases one can suggest as possible reasons, the permissive society, the development of antibiotic resistant strains, the contraceptive pill, earlier sexual maturity in girls, improved means of transport, holidays abroad etc. But, apart from the fact that the germ of syphilis has shown no signs of developing antibiotic resistance, there is no satisfactory explanation for the decline in the number of cases of early infectious syphilis.

Other interesting features of the last decade are the increase in the number of patients found to be infected with two or three or even more sexually transmissible diseases at the same time; also the increase in the number of individuals, especially teenage girls and young women, who were symptomless carriers of venereal and sexually transmissible diseases. There has been a decline in the number of prostitutes and an increase in promiscuous amateurs. Legislation affecting homosexual activity has resulted in an increase in the number of male patients admitting that they were homosexuals.

Contact Tracing:

A summary of the duties and work of the four V.D. social workers employed by the West Riding County Council was given in the 1970 Report. The vast majority of patients found to have venereal and sexually transmissible diseases at special clinics are given contact slips to give to the contact or contacts. In this method the patient acts as a contact tracer. It is usually an excellent method of getting secondary contacts to attend; but is much less successful in relation to primary contacts.

A primary contact is considered to be the source of the patient's infection. Secondary contacts are other people with whom the patient has had sexual intercourse, often during the incubation period, after acquiring a disease from the primary contact. Usually secondary contacts are very well known to the patient, such as a regular girl (or boy) friend, fiancé, or spouse.

The V.D. social workers have a particularly valuable role to play in finding and persuading primary contacts to attend for examination at special clinics. Quite often the primary contact is a symptomless carrier of infection and much tact, skill and persistence is necessary. Of 66 contacts dealt with by the social workers 78 per cent. were located and 68 per cent. attended special clinics for examination.

In line with the decrease in syphilis the number of antenatal patients found to have positive serological tests for syphilis continued to fall and in 1971 there were only 10 West Riding patients. Two of them were referred to special clinics and both were found to have the disease.

The writer is most grateful to the consultant venereologists in charge of the 16 special clinics and their staffs for their co-operation in providing statistical details of the number of West Riding cases diagnosed at the clinics; also to the West Riding V.D. social workers for getting some of the information and for their advice.

Thanks are also due to the confidential secretaries at the central office for collating the figures and their never failing help and loyalty.

RESEARCH PROJECTS

Survey of Childhood Cancers:

In previous Reports a review has been given of the department's participation in national surveys into childhood cancers conducted by Dr. Alice Stewart of the Department of Medicine, at Oxford University. The surveys have included the study of cancer ætiology in children who have died recently from malignant diseases also a control group of healthy children.

The administration of the current survey has passed to the Marie Curie Memorial Foundation and the title changed to the Juvenile Cancer Registry but continuity of all previous work and results will be ensured by the active involvement of the Oxford workers, and all processing and consequent evaluation of the data will remain at Oxford.

The present survey includes the investigation of deaths in the period 1961-70 and at the year-end of the 302 deaths relating to the Administrative County, enquiries into 253 cases and their age/sex paired controls had been completed.

Measles Vaccine Trial:

In the autumn of 1964 the Authority agreed to take part in a large-scale trial of protection from measles vaccines under the auspices of the M.R.C. Measles Vaccines Committee. The trial was planned to assess the value of the vaccines for general use, which necessitated a study of the degree and frequency of reactions following vaccination, also the extent and duration of protection afforded.

During October/November, 1964, and September/October, 1965, some 3,510 children in the susceptible age group of 10 months to 2 years, resident in certain areas of the Administrative County whose parents had voluntarily agreed to them taking part in the trial were vaccinated with killed vaccine, followed four weeks later with a dose of live vaccine. The children were followed-up by health visitors three weeks after vaccination to assess any reactions to the vaccines and at three, six and nine months to ascertain the incidence of measles. Subsequent annual postal follow-ups have been undertaken and visits by health visitors where appropriate.

The Committee's third report, published in 1971, confirmed its previous conclusions that there is a high protective efficiency and, as before, attacks of measles which did develop in vaccinated children were usually milder and required less medical attention than in those who were unprotected. Whilst this is so far satisfactory, with vaccine efficacy undiminished at better than 90 per cent. after three expected epidemics of measles, the children will continue to be followed-up to determine whether the immunity conferred is life-long or if booster doses should be given and, if so, the optimum age for their administration.

National Surveillance of Congenital Rubella Defects:

In July, 1970, the Department of Health and Social Security recommended that rubella vaccine should be offered as a routine to all girls between their 11th and 14th birthdays. This recommendation was implemented by the West Riding Health Department and was followed by participation in a national scheme for surveillance of congenital rubella defects.

The purpose of the scheme is long-term surveillance on a prospective basis to determine the effect of rubella vaccine on the incidence of congenital defects due to rubella.

The Northern Central Register for the surveillance programme is supervised by Professor Smithells, Department of Pædiatrics and Child Health, The University of Leeds. Pædiatricians, family doctors and local health authority staff are all involved in the scheme. The local health authority staff participate by means of a screening procedure whereby a finger-prick blood sample is sent to the central laboratory together with brief clinical details from:

1. Babies between 6-8 months because of a history of the mother having rubella during pregnancy.

2. All apparently-deaf children from 6 months to 5 years.

3. All children under 7 years who have a confirmed perceptive deafness.

Morbidity and Mortality Survey of Chromium Platers:

The Medical Research Council's Committee on Research into Chronic Bronchitis is sponsoring an investigation into past and present workers in the chromium plating industry in the West Riding geographical area; the survey is being conducted by Dr. H. Royle of York.

It has already been acknowledged that chromic acid fumes can cause respiratory diseases including carcinoma of the lung, but little is known whether workers involved in chrome plating are exposed to similar risks. The purpose of this survey is to ascertain the prevalence of chronic bronchitis and related disorders in individuals who during the past 30 years have worked for more than three months in chrome plating compared with a control group of industrial workers from the same area who have never worked with chrome.

Personal interviews with existing platers at their place of work were undertaken by Dr. Royle and for ex-platers and controls by health visitors. Additionally, health visitors followed-up defaulters and chromium platers who were known to have died.

Included in the survey were 198 cases and 40 controls from the Administrative County; 147 cases and 26 controls were successfully investigated, the remainder, in spite of extensive enquiries, were untraceable or refused to co-operate in the survey.

In an interim report Dr. Royle comments that cancer deaths in the platers and controls were in the ratio of 3:2 but, as the populations date back only to 1945, it is expected that more cancer deaths will occur in the platers in the next few years. Deaths of platers from respiratory disease, other than cancer, were also in excess in the ratio of 3:2. The information about morbidity has still to be analysed.

PART II

CO-OPERATION IN THE HEALTH SERVICE

DIVISIONAL ADMINISTRATION

See also Table 35 of Appendix A

CO-OPERATION IN THE HEALTH SERVICE

Co-operation with General Practitioners:

STANDING SUB-COMMITTEE ON CO-OPERATION:

This Committee met on four occasions during the year and discussed the following items:

January

International Certificates of Vaccination against Smallpox and Cholera. DHSS Circular 14/70.

Vasectomy Clinics.
Accidental Hypothermia. DHSS Circular 19/70.
Local Authority (Social Services) Act, 1970.
General Nursing Council Syllabus. DHSS Circular 18/70.
Notification of Meningitis.
Scandinavian Visit—Dr. Francis.

April

Family Planning.
Local Government Reorganisation.
Transfer of functions to Education and Social Services Departments.
V.D. Contact Tracing.
Sale of Welfare Foods in Clinics.
Cervical Cytology.
Developmental Pædiatrics.

July

Deafness in Early Childhood—DHSS Pamphlet (with LHAL 8/71 and C.M.O. 3/71).

Admissions to Old People's Homes—Proforma for completion by General Practitioners.

Psychiatric Patients—Administration of Drugs and Transport.
Safe Custody and Administration of Medicines—Code of Practice for Old People's Homes.

Computer Scheme—Vaccination and Immunisation.
Domiciliary Midwifery Difficulties.
National Surveillance of Congenital Rubella Defects. C.M.O. 6/71.
Home Nursing Service and Renal Dialysis.
Control of Infectious Diseases.

October

School Milk—Supplies to 7/11 year old children.
The Community Hospital.
Infestation—Scabies and Head Lice.
Cholera.
Children with Special Needs.
'Doctor' Parking Places.

Premises for Joint Use:

At the time of writing 108 practices comprising 283 general practitioners are being provided with main or branch surgery accommodation in 75 health centres and clinics.

New buildings completed during the year were:

'E' Type Health Centre	Date of Completion
Stannington	19th January
Brampton Bierlow	2nd February

Health Centres—Special Design

Castleford	28th April
Wetherby	30th June

General Practitioners in Maternity and Child Welfare Work:

The participation of general practitioners by sessional employment with the County Council is indicated in the tables below:

Infant Welfare Clinics	Total Doctors' Sessions	General Practitioners' Sessions	Percentage of sessions done by General Practitioners
1964	12,492	5,496	44
1965	11,761	5,844	49
1966	11,678	6,711	57
1967	11,307	6,679	59
1968	10,762	6,285	58
1969	10,187	5,930	58
1970	10,210	6,641	65
1971	9,545	6,254	65

Ante and Postnatal Clinics	Total Doctors' Sessions	General Practitioners' Sessions	Percentage of sessions done by General Practitioners
1964	3,011	1,267	42
1965	2,751	1,122	41
1966	2,398	1,123	47
1967	1,920	920	48
1968	1,787	893	50
1969	1,367	776	57
1970	1,078	644	59
1971	989	559	56

Facilities Offered to General Practitioners:

Rent-free Infant Welfare Sessions conducted in County Health Centres and Clinics by General Practitioners for their own patients with the Health Visitor in attendance

	Sessions	No. of General Practitioners involved
1964	Nil	—
1965	46	5
1966	58	6
1967	50	2
1968	147	11
1969	294	21
1970	453	36
1971	573	40

Rent-free Antenatal Sessions conducted in County Health Centres and Clinics by General Practitioners for their own patients

	Sessions	No. of Practices involved
1964	902	25
1965	1,456	36
1966	1,643	43
1967	1,927	51
1968	2,159	53
1969	2,381	57
1970	2,365	59
1971	2,849	64

Midwives attending Antenatal Patients in General Practitioners' surgeries (outside clinics)

	Sessions attended	Midwives involved
1964	1,945	67
1965	1,905	85
1966	3,600	105
1967	3,458	91
1968	4,380	104
1969	4,816	115
1970	4,668	120
1971	4,308	117

STAFF ATTACHMENTS: Health Visitors

At 31st December	No. attached	No. of Practices	No. of General Practitioners
1964	68	88	185
1965	128	163	355
1966	140	169	377
1967	153	202	416
1968	209	251	514
1969	205	259	550
1970	216	241	549
1971	215	248	554

Home Nurses

At 31st December	No. attached	No. of Practices	No. of General Practitioners
1964	33	51	110
1965	47	71	156
1966	70	99	233
1967	115	165	358
1968	196	249	541
1969	214	263	598
1970	215	266	601
1971	247	296	660

Midwives

At 31st December	No. attached	No. of Practices	No. of General Practitioners
1964	27	38	70
1965	43	47	106
1966	45	51	119
1967	49	54	119
1968	49	63	153
1969	49	64	148
1970	52	72	168
1971	46	64	151

Bulletin for General Practitioners:

Health Notes and the complementary *Divisional Medical Officer's Newsletter* continued to be issued quarterly.

Co-operation with Hospitals:

Maternity Liaison Committees:

Meetings were held in Doncaster, York, Barnsley and Sheffield. Items discussed included Family Planning, Perinatal Mortality Survey, Integration of Midwifery Services, Ambulance Arrangements for Early Discharge of Maternity Cases, Use of General Practitioner Units and the Admission of Infected Patients to Maternity Units.

Services for the Mentally Handicapped:

A series of meetings have been held with representatives of the Leeds and Sheffield Regional Hospital Boards. The object of these meetings was for joint discussion of Command Paper 4683 *Better Services for the Mentally Handicapped* and the preparation of a joint report on the proposals made by the Hospital and Local Authority Services to implement the recommendations in the Command Paper.

Co-operation with Other Services:

Survey of Young Chronic Sick and Handicapped Persons Living Alone:

Young Chronic Sick:

This survey was undertaken at the request of the Leeds and Sheffield Regional Hospital Boards. The main object of the survey was to assist the Hospital Boards in assessing the number of patients, in the 16-64 age group, living at home who really should be in hospital. Surveys in other parts of the country had suggested ratios varying from 1 bed to 5,000 to 1 bed to 10,000 population. On this basis hospital provision for the Sheffield Region would have been either 500 beds or 1,000 beds according to the survey on which the calculation was based. It was, therefore, clear that the Boards must have a more accurate basis for their future planning.

The survey was carried out by Divisional Medical Officers through the County Nursing Staff and with full co-operation by the General Practitioners. The results were as follows:

Regional Hospital Board Area	Population (in West Riding Administrative Area)	Total Young Chronic Sick	Per cent.	Requiring hospital admission			
				Immediate		Within foreseeable future	
				No.	Per cent.	No.	Per cent.
Leeds	1,244,323	1,294	0·10	33	2·6	124	9·6
Sheffield	549,697	375	0·07	11	2·9	57	15·2

On the information provided by this survey the bed/population ratio for the two regions would be as follows:

	Patients requiring hospital admission now or in foreseeable future		
Leeds R.H.B. area	157	=	1 per 8,000 population
Sheffield R.H.B. area	68	=	1 per 8,000 „

The survey involved the preparation of nominal rolls giving details of the individual cases and the opportunity was taken of making the information thus gained available to the Social Services Department.

Handicapped Persons Living Alone:

Circular LASSL 22/71 issued by the Department of Health and Social Security referred to a survey of the handicapped and impaired in Great Britain carried out by the Office of Population Censuses and Surveys. The survey revealed that a considerable number of very severely handicapped people were shown to be living alone in the community. It was estimated that this group would number about 8,000 people, and that the majority would be elderly women.

It was appreciated that many in this group would be receiving local authority services of one kind or another but authorities were asked, as a matter of urgency, to take steps to pool information available to their various departments with a view to identification of anyone in this category who wants but does not receive appropriate local authority service.

In response to this request a survey was undertaken through the services available to the Health Department, e.g., nursing staff, general practitioners, district council staff, etc. The figures revealed by this survey were as follows:

Division No.	*Area*	*Male*	*Female*	*Total*
1	Skipton	2	33	35
3	Keighley	3	23	26
4	Shipley	—	7	7
5	Horsforth	4	31	35
7	Harrogate	8	52	60
9	Rothwell/Wetherby	7	40	47
10	Goole	—	6	6
11	Castleford/Pontefract	1	8	9
13	Morley	6	27	33
15	Spenborough	16	68	84
18	Calder Valley	2	6	8
20	Colne Valley	3	21	24
22	Wortley	2	10	12
23	Hemsworth	5	15	20
25	Barnsley	1	14	15
26	Wath	31	136	167
27	Doncaster	—	7	7
29	Thorne	4	10	14
31	Rotherham	15	58	73
	Totals	110	572	682

Full details of the individual cases revealed by this survey were passed to the Director of Social Services for comparison with the results of a similar survey conducted by his department.

Working Parties with the Health, Education and Social Services Departments:

The Education (Handicapped Children) Act, 1970 and the *Local Authority Social Services Act, 1970*, both came into operation on the 1st April, 1971.

The legislation introduced by these Acts transferred a number of services from the Health Department. The responsibility for the services for mentally handicapped children, including the operation of the Junior Day Training Centres was transferred to the Education Department and the Social Services Department became responsible for the welfare of mentally disordered patients, provision of training centres and hostels for the mentally ill and mentally handicapped and residential accommodation for children suffering from mental disorder. Other services transferred to the Social Services Department included Nurseries and Child-Minders, Home Help Service, Care of the Unmarried Mother and Recuperative Home Treatment.

Having regard to the extent and complexity of the transferred services it was obvious that close co-ordination between the three departments was essential to ensure a smooth continuance of vital services which were well established.

To this end joint working parties were set up before the date of change-over and a full report of the activities of the Health/Education Working Party was given in the Annual Report for 1970. The need for liaison to continue after transfer of the services was apparent and a Co-ordinating Committee was established to succeed the working parties. Initially the Co-ordinating Committee consisted of the Heads and Deputy Heads of the departments involved together with the Deputy Clerk of the County Council.

At the meeting of the Co-ordinating Committee in July, it was stressed that after 1974 full co-ordination between the health services and the social services would be even more important than at present; and that the existing constitution of the Committee would not be appropriate for a proper consideration of field problems. It was therefore agreed to establish a Co-ordinating Group (Adults) and a Co-ordinating Group (Children), each Group to consist of three representatives from the Health and Social Services Departments with a representative of the Clerk's Department in the Chair. The groups would deal with matters concerning fieldwork and also with items referred down from the Chief Officers' Meetings.

The Co-ordinating Groups have met at intervals of approximately two months and have dealt with a wide range of subjects. These meetings have led to a better understanding between the departments and have provided a means of negotiation whereby difficulties arising at field level have been frankly discussed and, in some instances, solved to the mutual satisfaction of the departments concerned.

DIVISIONAL ADMINISTRATION

The divisional scheme of administration in the County was set up in 1947 and at that time consisted of 31 divisional areas. At the end of 1971 there were only 19 divisions due to a number of amalgamations.

The following changes have taken place in the senior divisional staff:

Divisional Medical Officers:

Division No. 20 (Colne Valley)	Dr. P. M. Sammon resigned 31st January.
Division No. 9 (Rothwell/ Wetherby)	Dr. E. M. Hargreaves appointed 22nd March.
Division No. 20 (Colne Valley)	Dr. J. P. Stuart appointed 26th April.

Divisional Nursing Officers:

Division No. 10/29 (Goole and Thorne)	Miss C. J. Badcock appointed 3rd May.

Principal Nursing Officer:	Mrs. I. Endean promoted to the post of Principal Nursing Officer from Divisional Nursing Officer, Division No. 15 (Spenborough) on 1st November.

A list of senior staff and other details concerning each division is given in Appendix A.

The co-ordination of the work of the divisions is undertaken through the work of the Divisional Medical Officers' Conference which meets every month other than August. All major policy and its implementation is discussed at these meetings to ensure that all senior staff may make an appropriate contribution to the consideration of policy and in addition all those problems which arise in divisions are also discussed for clarification and further action.

PART III

LOCAL HEALTH SERVICES

Care of Mothers and Young Children

Midwifery

Health Visiting

Home Nursing

Ambulance

Prevention of Illness, Care and After-Care

Health Education
Renal Dialysis

See also Tables 36 to 50 of Appendix A

Dental Treatment of Expectant and Nursing Mothers and Children under Five:

The Chief Dental Officer reports:

The Local Authority Dental Service for expectant and nursing mothers was designed to guarantee priority treatment to this class of patient. This treatment is now, for the most part, readily available to them in the National Health Service and the number attending County Dental Clinics for inspection during the year is a mere 356.

Efforts continue to inform parents of the dental service for their pre-school children and to persuade them to avail themselves of it. Liaison between medical and dental staffs, particularly in the case of developmental assessment clinics, together with a poster specially designed by Mr. Metcalfe have probably contributed to the increased attendance for inspection of these children at County Clinics this year. The number seen however is still very small and almost 20 per cent. of them attended initially for the relief of pain.

With the staff available and the prevalence of caries in the pre-school child being what it is, it is certain that if response to propaganda from this age group became substantial, then the service to school children and the permanent teeth would suffer. Fluoridation of the drinking water would beyond doubt go a long way towards resolving the problem of dental decay and the misery of toothache in these young children.

Phenylketonuria:

There were six new cases of phenylketonuria confirmed during 1971.

This is the first complete year that all children born in the Administrative County area had a Guthrie test taken about the sixth day after birth as a screening procedure for phenylketonuria. It is interesting to note that, during this year, the maximum time interval between birth and diagnosis was two weeks, which is an improvement on past years. As early diagnosis and treatment are necessary to prevent retarded development of the affected child, the Guthrie test would appear to be more effective than the 'Phenistix' test previously used.

Details of the cases are as follows:

Case 1 Boy, J. C., born 2.3.71.
Positive Guthrie test 8.3.71.
Detained in hospital. Placed on strictly-controlled diet.

Follow-up Report (May 1972).
Is making consistently good progress in all areas of development.

Case 2 Boy, J. E., born 7.6.71.
Positive Guthrie test 11.6.71.
Admitted to hospital. Dieting began 18.6.71.

Follow-up Report (May 1972).
Strictly-controlled diet; attends hospital regularly.
Has made splendid progress and development is above average.

Case 3 Boy. P. S. T., born 1.6.71.
Positive Guthrie test 7.6.71.
Detained in hospital. Placed on strictly-controlled diet.

Follow-up Report (May 1972).
Attends hospital monthly. Has individually-tailored diet.
A rather large, flabby infant.

Case 4 Girl, K. W., born 29.7.71.
Positive Guthrie test 13.8.71.
Admitted to hospital. Placed on strictly-controlled diet.

Follow-up Report (May 1972).
Normal progress has been made. Assessment tests have been completed satisfactorily.

Case 5 Boy, D. H., born 24.11.71.
Positive Guthrie test 30.11.71.
Admitted to hospital. Dieting began 8.12.71.

Follow-up Report (May 1972).
Attends hospital monthly.
Has tolerated diet quite well and is making good progress.

Case 6 Girl, J. T., born 24.8.70.
Placed on low phenylalanine milk diet as child's blood phenylalanine was raised at times.

Follow-up Report (April 1971).
Pædiatrician unable to confirm case as one of true phenylketonuria; temporary enzyme defect suspected.

Follow-up Report (June 1972).
Confirmed as a true case of phenylketonuria.
Strictly-controlled diet; attends hospital regularly.
General development satisfactory.

Ortolani Testing for Congenital Dislocation of the Hip:

Since 1965, the number of cases of possible congenital dislocation of the hip referred for specialist opinion has increased from 61 in 1965 to 552 in 1971. The number of confirmed cases has correspondingly risen from 17 in 1965 to 142 in 1971.

It is of interest to note that, in 1970, only 35 per cent. of the confirmed cases were referred by West Riding staff and this figure rose to 56 per cent. in 1971. The main increase in referrals by local health authority staff has been by the health visitors and these have tended to be referred at an older age, although within six months of birth. As the introduction of developmental screening for all children by health visitors was completed throughout the County by the middle of 1971 and as this includes a further test for congenital dislocation of the hip at three months, it would appear that the screening programme is already proving successful in finding cases of congenital dislocation which were missed previously. The total increase in confirmed cases referred from all sources points to an increasing awareness of the importance of early diagnosis of this condition if the child is to walk at the normal age. Although the total referrals to specialists show that many cases are not congenital dislocation of the hip, even so 173 of the total of 552 suspected cases discovered during the year were kept under observation and this highlights the fact that it is sometimes difficult to make a definite diagnosis at a first examination. The part played by local health authority staff is a screening one and the referral of all doubtful cases to a specialist is the only way to ensure that no child reaches the age of walking before a diagnosis is made.

Developmental Assessment of Pre-School Children:

Screening of developmental progress of pre-school children by members of the health visiting staff was gradually started throughout the County during 1971. By August, 1971, all the divisions had introduced the scheme starting at birth and some divisions were able to include children born before 1971 in their screening process.

Fifty-seven thousand one hundred and sixty-two individual children were screened by health visitors during the year, 26,085 of whom were born in 1971. (Total live births for the County Administrative Area was 30,687). Of all children screened, 3·2 per cent. were referred for further examination by a local authority doctor trained in developmental assessment techniques. Of the children examined by these doctors, 37·5 per cent. were referred for further investigation and 39 per cent. were kept under observation. Fifteen per cent. were placed on the County's observation register and 5·5 per cent. on the handicap/disability register. These were children who were found to have defects following screening tests by health visitors and the numbers do not include those pre-school children placed on either register because of defects brought to light in other ways, e.g. congenital malformations, letters from hospital consultants, etc., which were the only means of recognising children requiring help for some defect before this screening procedure was started.

Special emphasis is being placed on the early recognition of squint and of visual defects. During the year, 711 children were referred for specialist advice with probable squints. Eight thousand six hundred and fifty-three children between three years and five years were tested for visual defects, of whom 204 needed to be kept under observation and 151 were referred for a further opinion as to whether treatment of the defect was required.

Assessment of developmental progress must be an ongoing process and the scheme used by the County will need to be in use for some time before it can be evaluated accurately but it would appear that routine screening by health visitors is resulting in the earlier discovery of children with defects, e.g. congenital dislocation of the hip (referred to on page 97), squints, visual defects and a percentage of miscellaneous defects. This means that help and/or treatment is being given as soon as possible to all children who show even minor deviations from the accepted normal development for their age, thus enabling them to develop to their full potential, physically, emotionally, intellectually and socially.

Welfare Foods:

At 31st December, 1971, there were 289 distribution centres in the County for the issue of welfare foods, of which 212 were health or child welfare centres.

THE COUNTY NURSING SERVICE

On 1st April, 1971, Miss Harris was designated Principal Nursing Officer. Formerly Deputy County Nursing Officer, Miss Harris will continue to act for the Chief Nursing Officer when the latter is absent.

Miss Tattersall was designated Principal Nursing Officer (Health Education).

Mrs. Endean commenced duty as Principal Nursing Officer on 1st November, 1971. Mrs. Endean was formerly a Divisional Nursing Officer.

In 1971 the County Council agreed to an inclusive establishment of field staff and nursing officers (first line management) instead of three separate figures for midwifery, health visiting and home nursing.

In the following paragraphs, therefore, allocations from the one establishment are given to maintain comparison with earlier reports.

DOMICILIARY MIDWIFERY

Staff Allocation:— 195 including a reserve of 3, and 10 nursing officers.
In post 31st December, 1971:

Nursing officers, midwivery	7
Nursing officers, home nursing/midwifery ...	3
Whole-time midwives	149
Part-time midwives	12
Whole-time home nurse/midwives	37
Part-time home nurse/midwife	1
	209

Whole-time equivalent	184
Changes of staff included:	
Appointments—Nursing officers	10 (including 8 from own staff)
Midwives	27
Resignations	12
Retirements	8
Transfers to other services	2
Death	1

In-Service Training:

Thirty-five midwives attended statutory refresher courses outside the County.

Thirty-five county midwives, and eight from local hospitals and county boroughs, attended a course at Grantley Hall. Ten health visitors also attended, and both groups of staff welcomed different viewpoints.

One midwife attended for training in family planning methods.

Seventeen midwives from two divisions attended the Jessop Hospital for Women at Sheffield for a week's in-service training into new methods and current research.

Ten midwives from another division attended the Northern General Hospital at Sheffield for a week. A request for midwives from the Northern General Hospital to visit the district midwives was received with great pleasure.

Attachment to General Practice:

The present position is shown on page 89. It will be appreciated that the smaller numbers of midwives available makes firm attachments to one practice only not possible.

Emergency Obstetric Units:

There were 34 calls on this service during the year.

Cars:

One-hundred and fifty-six midwives used cars, 18 of which were provided by the authority.

Radio-telephone Communication:

With the help and co-operation of the officers of the county ambulance service, a pilot scheme to assess the use of radio-telephonic communication with the midwifery service commenced in the Rothwell area on 25th October, 1971.

Seven midwives are taking part, using car radios, with the Castleford ambulance station as the 'control'.

The advantage of contact being possible with the midwife during the hours away from the 'base' was quickly evident, and personnel rapidly overcame their natural apprehension of a complex but valuable system.

The results of this trial are awaited with interest.

HEALTH VISITING

Staff Allocation:— 431 including a reserve of 4·5, and 24 nursing officers.
In post 31st December, 1971:

Nursing officers	21
Qualified health visitors—whole-time	264
Qualified health visitors—part-time	23
Assistants to health visitor—whole-time ...	66
Assistants to health visitor—part-time	65
Tuberculosis visitor—whole-time	1
	440
Whole-time equivalent	396

Changes of staff included:

Appointments—Nursing officers	21	(including 19 from own staff)
Qualified health visitors ...	41	
Assistants to health visitor ...	47	
Resignations—Qualified health visitors	25	
Assistants to health visitor ...	7	
Retirements	11	
Transfers to other services	5	
Transfers to health visitor training	11	
Death	1	

Attachment to General Practice:

This continued, as shown on page 89.

In-Service Training:

The in-service training programme included 28 health visitors attending courses outside the county—these courses usually come at five-yearly intervals for members of staff.

The course at Grantley Hall was attended by 36 health visitors and 13 assistants to health visitor.

The chief nursing officer and five divisional nursing officers attended management courses.

Training in the detection of hearing loss continued.

Dr. Robertshaw gave much initial help on developmental assessment tests throughout many divisions. In the remaining areas this preparatory work was undertaken by divisional medical staff.

Family planning training was provided for 15 health visitors and assistants to health visitor.

Health Visitor Training:

Twenty-two students qualified in 1970/71. Twenty-eight students were accepted for courses commencing October, 1971.

Two health visitors received courses of preparation for fieldwork instruction.

Cars:

Three-hundred and fifty-two health visitors and assistants used cars, three of which were provided by the authority.

Statistics:

Since figures given on page 185 relate only to first visits to any particular child or adult, the real volume of work undertaken is not fully shown. The report of the health visiting survey given in pages 14 to 19 will give a clearer overall picture.

HOME NURSING

Staff Allocation:— 328 including a reserve of 4·5, and 18 nursing officers.

In post 31st December, 1971:

Nursing Officers	15
Home nursing sisters, S.R.N.—whole-time ...	256
Home nursing sisters, S.R.N.—part-time ...	32
Home nurse/midwives—whole-time	37
Home nurse/midwives—part-time	1
Home nurses, S.E.N.—whole-time	16
Home nurses, S.E.N.—part-time..	4
	361
Whole-time equivalent	324

Changes of staff included:

Appointments—Nursing officers	15 (all from own staff)
Home nurses	73
Resignations	32
Retirements	6
Transfers to other services	8



Ambulance Service Headquarters—Exterior View of County Control



Ambulance Service Headquarters—County Control, Operations Room



Ambulance Service Headquarters—Operations Room, County Control



Proposed Ambulance Service Training School, Keighley, before adaptations

Attachment to General Practice:

. The position is shown on page 89.

In-Service Training:

Forty-six nursing sisters attended a course at Grantley Hall, and seven sisters joined the course from other authorities.

Three members of staff attended at Lodge Moor Hospital, Sheffield, for training in the management of renal dialysis at home.

Other members of staff attended psychiatric hospitals to study particularly the use and side effects of Modecate—a drug frequently given during nursing duties. Other hospitals offered facilities for observation of new techniques, and training in any skill likely to be needed for patients about to be discharged.

Training:

Twenty students completed the course and all were successful in gaining the National Certificate in District Training.

Cars:

Three-hundred and fifty-two home nursing sisters used cars, 79 of which were provided by the authority.

Statistics:

These are given in detail on page 186.

The trend towards attendance by ambulant patients at health centres and surgeries for nursing treatment has increased. An additional 18,000 treatments were given by county nursing staff outside the home in 1971. In this context, a reduction of 17,479 home visits to a caseload reduced by 1,237 on 1970 figures is to be expected. Every care is taken, however, to ensure that the needs of the bedfast and housebound are fully covered—where necessary, early in the day.

Day and Night Nursing Service:

The object of this scheme, which is provided as an extension of the Home Nursing Service, is to provide a day and night nursing service for temporary periods—usually in an emergency or during the terminal stages of illness—to afford some measure of relief to relatives who are under a considerable strain resulting from caring for patients over a long period. Trained nurses, persons with nursing experience and 'sitters-in' are employed in the service. Whilst the service is not one which is called upon frequently, it is one which can, nevertheless, be of immense benefit.

During the year, the service was used in 16 divisions: 278 cases were provided with 16,176 hours of service at a cost of £6,460.

AMBULANCE SERVICE

Ambulance Headquarters and Control, 'Threelands', Birkenshaw:

From its inception in 1948, the Ambulance Service of the West Riding of Yorkshire County Council has expanded from a fleet of 106 ambulances and 150 staff to one of 207 ambulances and 620 station staff.

The County is served by 26 Ambulance Stations, three Agency Services and the Hospital Car Service, in total conveying 805,171 patients and covering 5,283,352 miles per annum.

The original Headquarters, including the Central Vehicle Workshops, were in premises in York Street, Wakefield, which to say the least were indescribably inadequate.

In 1951, part of Oakroyd Hall, Birkenshaw, the main Hall of which was used as a County Children's Home, was occupied for use as Ambulance Headquarters, Control and Ambulance Station, and a Central Vehicle Workshop was built in the grounds.

In July, 1970, the Station moved to new purpose-built premises at Gildersome. The five acre estate of 'Threelands' was purchased by the County Council in 1968 and consisted of a large Victorian house, outbuildings, caretaker's house and lodge in a setting of mature trees and gardens.

Headquarters staff moved into 'Threelands' in September, 1970, and County Control became operative in July, 1971, Central Vehicle Workshops remaining at Oakroyd Hall, Birkenshaw.

The Headquarters are accommodated in the former house, which has been adapted to provide administrative office and storage facilities for the County Ambulance Officer and his staff. Care has been taken to retain the character of the old buildings and, at the same time, to provide accommodation to the best modern standards.

Heating is by low temperature hot water with fan assisted convectors to the principal rooms with radiators elsewhere. Two boilers are provided which are coal fired with automatic stokers and hot water is provided by a calorifier.

The electrical installation includes a stand-by diesel generator which operates automatically if the public supply should fail.

Mechanical ventilation is provided to the principal rooms and an electric impulse master clock system has been installed throughout both buildings.

The construction of the Control Centre is of brick with a steel frame on a concrete base, with reinforced concrete floors and timber roofs. Floors are finished in vinyl asbestos tiles, carpet or ceramic tiles as appropriate and walls are generally plastered.

Ample car parking facilities which have been designed into the existing gardens and woodlands are included in the scheme.

Headquarters comprises 24 staff, covering General Office, Finance, Supplies and Training Sections. In addition to the office accommodation, there is a conference room and dining room.

There is access from within the Headquarters building into County Control which houses the main control room and other offices for the Supervisor, planning, Telex, G.P.O. switchboard and stores. Staff being on shift work, the control is self-contained with its own dining room and cloakroom facilities. The basement of the control building houses G.P.O. and radio equipment and also provides space for storage of bulk supplies. The Headquarters has its own Y.E.B. sub-station in the grounds and a stand-by generator for emergency lighting and power supply.

The Control and Operations wing is planned as a separate unit and is linked with the Headquarters building at ground and first floor levels. It contains the Control Room which is in continuous operation over a 24 hour period and from which ultimately all messages concerning the Ambulance Service are received and directed for the entire County area. The room is designed to provide pleasant conditions for the operators whose work is often long and arduous and has received special acoustic consideration with the provision of carpeted floors and double glazing to windows. Control is operated through eight consoles with a main central console.

Since 1966, eight stations at Honley, Brighouse, Todmorden, Menston, Shipley, Pudsey, Keighley and Gildersome have been under central operational County Control. The new County Control is scheduled to take over direct control of stations at Harrogate, Pateley Bridge, Ripon, Bramham, Sherburn in Elmet, Castleford, South Kirkby and Wakefield in April, 1972. The South Yorkshire Stations at Bentley, Maltby, Wath upon Dearne, Hoyland and Penistone, should have come under County Control in 1972-73 but this has been deferred pending the publication of the White Paper on the Reorganisation of the National Health Service. Skipton and Barnoldswick Stations will be absorbed at a later date, whilst Settle and Goole Stations will remain under Station control.

Under the County Control system, all demand for ambulances—'999's,' Hospitals, Doctors, public calls etc., no matter where made, arise in the Control room where all journey planning is carried out exercising control of vehicles and crew at all times.

The County Control is fitted with the most modern G.P.O. equipment including key and lamp units and has direct telephone contact with all Ambulance Stations and with major hospitals served. Telex machines installed in the Control and at all stations facilitate the passing of bulk case loads to stations.

The Control provides the nerve centre of the radio telecommunications network covering the whole County whereby radio contact is maintained with all vehicles. The telecommunications manufacturers gave close collaboration in the design of the console units and the provision of efficient radio facilities in the Control and throughout the County network.

Experience over the past five years of the central control of eight stations has fully justified the intention to expand to full County Control. Centralisation of operational control provides a more efficient service to the patient whilst effecting economy by the improved utilisation of vehicles and manpower.

Poison and Overdose Cases:

Some time ago, the Department of Health and Social Security published a report of a Joint Sub-Committee of the Standing Medical Advisory Committee of the Central and Scottish Health Services Council, which contained a comment that Ambulance Services apparently had very little information or statistical records regarding their conveyance of poison and overdose patients.

In consequence of this, a report form was introduced into the Service to be completed by the crew conveying these types of cases and it shows type or suspected type of the poison or overdose; samples taken to hospital where appropriate; treatment given by the crew and condition of patient when first seen and on arrival at hospital. The information from the forms is analysed centrally and has proved to be most interesting and valuable in that, when considered necessary, crews have been interviewed through the Training Staff and specific cases discussed in detail with a subsequent feed-back for use in the Training School. The information also provides a broad picture of the trend in these cases, both in relation to the number requiring conveyance by ambulance and to the types of poison or overdose involved—interesting to the general subject of public health and social matters.

Statistics for year ending December, 1971

Total patients conveyed	833

Type of Poison or Overdose

Drugs, medicines, tablets	563 patients
Household goods, bleach, disinfectant etc.	42 patients
Gas	6 patients
Alcohol-drug combinations	19 patients
Not known by ambulance crew	203 patients

The main types of drugs were Mandrax, Mogadon and Tuinol.

Note: The figures quoted refer to the number of patients in respect of whom reports were completed by the crews. Due to unavoidable circumstances, some forms were not completed but the number is not so significant as to invalidate the analysis.

Statistics:

The increase over the previous year of 37,789 patients carried by the Direct Service was contained with less additional mileage as a result of effective operational control. The continued increase in total patients conveyed was in respect of out-patients, with a heavy demand at certain centres in Geriatric and Psychiatric patients conveyed to Hospital Day Clinics.

For details of statistics, see Appendix 'A'.

Vehicles:

The policy of standardising the ambulance fleet on Ford Transit chassis was continued with a replacement quota for the year of 20 ambulances. Due to the success of experimenting with five standard saloon cars for sitting case work, 20 ambulances were replaced by 20 Austin 1800 cars. Six additional ambulances were also obtained, making the total fleet 185 ambulances and 25 cars.

The introduction of cars as sitting case vehicles is without doubt an aid to improved journey organisation and patient care. Further experience will decide the exact proportion of cars to ambulances required to derive optimum value from the fleet.

Vehicle Workshops:

An indirect group bonus scheme was introduced in February, 1971, since when there has been a slow but sustained improvement of the performance of the Workshop. The overall objectives have not yet been reached but should be attained when present remaining problems have been resolved.

Building Programme:

The Department of Health and Social Security decided that the time was not opportune for the erection of a purpose-built Training School in the grounds of Headquarters, Birkenshaw, and has agreed to lease to the County Council the former Nurses' Home at the Keighley Victoria Hospital to replace the present inadequate Training School at Elm Bank, Cleckheaton. The new accommodation is expected to be ready by about July, 1973, and will enable two streams of students to be catered for simultaneously, thus increasing the number of places from 24 to 48. The scheme includes messing and kitchen facilities, classrooms, syndicate rooms, bar lounge, caretaker's flat and individual bedrooms for all students.

The second phase of the new Ambulance Headquarters at 'Threelands', Birkenshaw, Bradford, including Central Control Room, Conference Room and messing facilities was completed and occupied in July, 1971. An official opening ceremony was held in the grounds on the 7th September, when the building was dedicated by the Reverend G. Chappell, Vicar of Birkenshaw and formally opened by Mr. Vernon Whitaker, O.B.E., F.I.A.O., the former County Ambulance Officer.

Work has proceeded throughout the year on the new ambulance station at Castleford with accommodation for 15 vehicles, plus three service bays and completion is expected in April, 1972.

The three-bay garage extension at Skipton and the new mess room with locker room and storage accommodation at Menston were also completed and brought into service during the year.

The two-bay garage extension at Bramham, with additional mess and storage space is almost ready for occupation and work has commenced on the three-bay extension at Sherburn. The County Architect has also programmed two major station extensions at South Kirkby and Hoyland and is seeking the necessary approvals.

A site has been found for the new Barnoldswick station but there was some opposition but every effort was made to resolve this situation in order that a start could be made on the six-bay station in the next financial year. At the time of writing agreement has been reached and the station will be established on a site at Brogden View. Negotiations are proceeding for the site for a sub-station at Anston but the search for sites at Thorne, Harrogate and Keighley have so far been unsuccessful.

Training:

The Training School again met a heavy commitment throughout the year, catering for six basic six-weeks and five two-weeks refresher courses. Student intake, apart from our own service, came from 16 other ambulance services.

In-service training, both pre-school and follow-up training has continued but on a very restricted basis due to the non-availability of the few school staff able to undertake this work.

Competitions:

The Annual Inter-Station Competition was held in April, consisting of Drive, Attendant and Team tests. The winners went on to represent the service in the Regional Competition held at Bridlington in June, and came first in the Team Test, first in the Driving Test and fourth in the Attendant Test, winning the Victor Ludorum trophy.

Our winning team (from Goole station) and a driver (from Wakefield) together with the winning attendant (from Rotherham County Borough), went forward to represent the Region in the National Competition Final held at Harrogate in August and gained the following awards: Team Test, Runners-up; Driving Test, First.

Incentive Bonus Schemes for Ambulance Crews:

The County Council contracted with a firm of consultants to introduce an incentive bonus scheme for ambulance crews. Their main attempt was to establish a new system of journey planning based on mathematical criteria to improve the number of patients moved per man hour at a reduced mileage. So far, such attempts have failed, leaving the inception of a bonus scheme problematical. It could be inferred that having withstood the attempts at improvement, the operational organisation of the service has proved its high standard of efficiency.

Union Activity:

The year has been marked by strong claims by the National Union of Public Employees aimed at various matters, mainly the abolition of the Vehicle Task system as carried out by ambulancemen; an improvement in the plus rate for shift leaders; and acceptance of certain conditions in the manning of ambulances. All these claims were the subject of negotiations at the end of the year.

The County Council has agreed that a course be held for the training of Shop Stewards as a joint effort between Management and the Union and this will take place in 1972. It is hoped that this should lead to improved personnel relationships.

Agency Services:

During the year, two agency services have ceased and been replaced by sub-stations—Thorne and Grassington allied to main stations at Bentley and Skipton respectively.

A further agency at Clitheroe was closed and replaced by a contractual arrangement with Lancashire County Council, supplemented by additional cover from our Barnoldswick station.

Arrangements are in hand to establish a sub-station of Settle at Sedbergh to replace the existing St. John Agency Service.

Settle Station Mountain Rescue Unit:

It is pleasing to record that this station continues to co-operate fully with the Cave and Fell Rescue organisations, the Police and Fire Services on pothole and fell accidents.

The Ambulance Service provides radio communication from the incident back to Settle station and the detailed knowledge of the ambulancemen of the difficult terrain is invaluable both in this respect and in discovering vehicle access to the incident. Work is often hazardous and in bad weather conditions but the ambulancemen accept this in helping to provide an efficient service to those unfortunate enough to suffer such accidents.

PREVENTION OF ILLNESS, CARE AND AFTER-CARE

Health Education:

There have been two interesting developments this year: one of a general nature—the appointment of First Line Managers in the Divisions—has had an impact on the health education activities resulting in a more planned and co-ordinated approach; the second is the work of Dr. E. M. Harvey, Departmental Medical Officer, concerned only with health education within the schools. An account of her work is included in the Special Review Section of this Report.

Despite the shortage of staff in some areas, health education has continued to increase, and there is emerging a feeling both among medical and nursing colleagues, and also teachers, that health education is a vital part of general education. In the health professions we often underestimate the amount of health material that is contained within general education in schools. Though not described as health education on the school timetable, it is implicit in subjects like human biology, physical education, religious instruction, and the new courses which are covered by such titles as humanities and liberal studies.

The Joint Working Party on Health Education, composed of health and education staff continued to meet, and a further combined study day for the two disciplines on 'Drugs and Young People' was held at Bretton Hall College of Education at which 150 people attended. A meeting was held at Mexborough Grammar School between some members of the working party and teachers in the south of the County to consider the difficulties and methods of teaching health education in schools.

The amount of personal health education undertaken by health visitors, midwives and district nursing sisters in the homes is never recorded, but it is there that attitudes are often changed. Health visitors and midwives co-operated to produce a syllabus for the needs of the expectant mother.

A visit to the County by the Health Education Council's compact mobile unit provided a unique means of extending in-service training courses and direct education to the public. This gave the staff the opportunity of using modern technical equipment, like closed circuit television.

The Royal College of Physicians' Report *Smoking and Health Now* resulted in greater interest in the anti-smoking activities. Two anti-smoking clinics were held and were reported in *Health Notes*, 1972, *4*, 19, and reproduced below are the comments of the Divisional Medical Officers concerned.

Harrogate: Report by Dr. Hepple.

"An experimental anti-smoking clinic was held in Harrogate in May, 1971; it was considered worthwhile to try the effect of intensive support for five days on a small group who were personally involved with the problem of giving up cigarettes.

The proposal was advertised in the local press and those interested were asked to write or telephone to the Health Department. Thirty-nine people indicated their interest.

Clinics took place every evening from Monday to Friday in order to give maximum support during the early days of abstinence. Twenty-one people attended the first session. Nine attended every night, five attended four sessions, and nine attended three or fewer. Sixteen attended the fifth session.

The first session after enrolment started with a short introductory talk by the Divisional Medical Officer. The audience was then split into groups of four who got acquainted while they were filling in a short questionnaire on their smoking habits. Coffee was served, and each group of four was split in two, each pair arranging to give mutual support, by telephone if necessary.

Subsequent meetings commenced with an exchange of experiences by everyone and the completion of a questionnaire on withdrawal symptoms. This was followed by: Tuesday, film 'Countdown'; Wednesday, talk by a doctor; Thursday, film 'Smoking and You' and a cartoon; Friday, summing up and discussion.

Those attending arranged two informal meetings in the clinic during the following week, and an official follow-up meeting was held six weeks after the termination of the course. The reported results at that time were that out of the 14 people who attended four or more sessions, eight had stopped smoking completely, two had cut down on the amount smoked and one man had continued as before; three people did not attend for follow-up.

This result must be regarded as well worth the large amount of professional time devoted to the effort. It would, of course, be very expensive in time to hold sufficient clinics of this type to have any appreciable impact on the smoking population."

Goole: Report by Dr. Lowe

"Clinics were held for two hours each evening for one week in October, at a child welfare centre. Publicity was given by advertisements in the local press, by posters displayed in prominent places and I also gave an interview on Radio Humberside.

Eleven men and one woman attended the first session and were given a talk on the facts and reasons for giving up smoking, followed by a short discussion on ways of doing this.

Fourteen persons turned up on the second evening—a discussion session—some were disappointed that no magic cure for giving up smoking could be expected.

By Wednesday we were getting to know each other; one man had given up smoking completely and two others had reduced to under five cigarettes; two women had no more than a few puffs and were convinced that they could abstain. An elderly lady who smoked 30 per day, but only came on this one session, wrote later to say that she had cut down considerably. Group discussion seemed to help as much as anything else we did, and after discussion the group were impressed by the film 'This is Your Lung'.

On Thursday evening results were better. Several had now given up smoking, others had cut down, and all were obviously enjoying the sessions. Many were informing relatives, friends and workmates; two young men brought along their fathers, and were clearly an influence for good at their workplace. Discussion was again followed by a film 'Dying for a Smoke' and a cartoon film 'No Smoking'.

Numbers were down on Friday but there were one or two new faces together with the stalwarts who had attended most of the week. I was pressed to continue the clinics the following week and two further sessions were arranged for the following Monday and Thursday.

Out of the 31 total attenders, 15 attended one evening only; several felt that they had received the necessary stimulus in order to give up; others were obviously sceptical and not prepared to make the effort. Six others came on two evenings and some had reduced to half or less of the previous amount smoked. Eight who attended more than twice have either given up completely or are down to four or fewer cigarettes a day. Three other people came to the clinic on the Thursday in the second week and said they would come again if notified.

I realise that the small numbers who attended the clinics were only the tip of the iceberg but I am told that there is a great deal of talk about the anti-smoking campaign in Goole, through the advertisements and posters and excellent publicity afforded me by the *Goole Times* in two interviews which I had with a reporter before and after the week of clinics. I never lose the opportunity to further the cause and I am hoping that the time is not so far distant when smoking will become 'Non-U', and the school children will no longer be tempted."

REVIEW OF ACTIVITIES—HEALTH EDUCATION UNIT:

Visual Aids:

Over the past number of years the demands for exhibition materials on a wide range of subjects has increased, and last year was no exception.

The Puppet Home Safety Exhibition has always been in great demand as a teaching aid for both children and adults and a second puppet display was designed and commissioned. This is an extension of the original and emphasises the safety aspects in relation to outdoor activities.

Number of exhibitions:

Exhibit	*Number of venues*	*Number of days on display*
Puppet Exhibition	25	259
Medicines Display	9	105
Smoking and Lung Cancer Display	25	157
Nursing Stands	4	72
Factors affecting the unborn child	6	132
Other Displays	98	382

We are always conscious of the need to help field workers improve their teaching techniques, subsequently a series (set of nine subjects) of teaching and lesson preparation notes on different subjects were produced in conjunction with divisional staff. These have had a wide distribution throughout the County.

The film library now holds 103 sound films, a high proportion of these are in constant demand and it will therefore be appreciated that the repair and maintenance of both films and projectors demands the increasing attention of a technician.

In-service Training:

The Health Education Officer arranged in-service training courses to promote and create an interest in health education and to give field staff the opportunity of developing their teaching skills. The following courses were held:

1. Grantley Hall Residential Course—"Some Health Problems Today". The course was aimed to increase the knowledge of the drug problem, and demonstrate modern methods of teaching first aid. Twenty-three participants attended the course.

2. Three-session course—"Home Safety" held in the West Riding County Library Headquarters and was a repeat of a course held in the previous year. Course tutor and lecturer was Mr. K. Shaw, M.I.H.E., Home Safety Liaison Officer, Northern Region, Royal Society for the Prevention of Accidents. Twenty-two members of staff attended.

3. Health Education Council—Mobile Unit and in-service training course. This was held in two divisions, at Harrogate, when representatives from surrounding Authorities attended and in the Morley division. The subjects concerned in the project were 'stress' and 'obesity' and involved schools and the general public.

Support for field workers, and individual help was given to all grades of staff and the Health Education Officer attended working parties and health staff meetings to disseminate knowledge and helped planning components of health education programmes.

Review of Activities in Divisions:

The support by nursing officers is underlined in the following two reports:

Dr. Stalker, Divisional Medical Officer (Doncaster) commented:

"Five sessions were planned for health visitors to promote interest in health education and Dr. Beale and nursing officers were involved. Discussions on subjects presented were developed to fit into the current programmes in schools."

Similarly, Dr. Stuart, Divisional Medical Officer (Colne Valley) wrote:

"Twelve clinics in the Division hold mothercraft/relaxation classes weekly. They are shared between midwife and health visitor covering a programme of eight talks. Fathers are encouraged to attend one evening session. I feel that midwives and health visitors enjoy formal health education with which they are involved and encouragement for them to continue is given by their respective nursing officers. Health education given by district nursing sisters is less formal being more domestic and readaptive by nature but she contributes very much to the well-being of the community by encouraging a healthy attitude of mind and approach to life."

Shortage of health visitors in some areas has resulted in enforced cancellation of some health education classes in schools whilst in other areas teachers are well able to deal with this subject, but refer to the divisional medical officers' staff for guidance and advice, as outlined by Dr. Walters, Divisional Medical Officer (Hemsworth):

"Acute staff shortages have curtailed health education and some classes and mothercraft classes were amalgamated. Programmes of talks which continued until summer have been suspended by mutual agreement with the teacher concerned who felt capable of continuing with help from the health visitor when required."

In other areas health education continued to expand and many health staff find satisfaction in teaching health with good response as instanced by Dr. Ireland, Divisional Medical Officer (Morley):

"During 1971 health education was taught in every senior school in the area, and six junior schools, two infant and one nursery school. The extract of reports from health visitors illustrate the type of work and response.

'I thought the talk on "Care of Skin" made quite an impression on a group of 9-11 year olds. This produced many intelligent questions and paved the way to a better understanding of themselves. A week later I met a mother who said "I hear all about your talks in school and it is a good idea". Similarly just recently I had an 18 year old mother of twins I had taught in school and asked her if she had benefited by the lessons on parentcraft. The answer was "Yes" because it made her more inquisitive, and she felt confident to ask questions without feeling embarrassed.'"

An expansion of health education was reported by Dr. Battersby, Divisional Medical Officer (Shipley):

"Health education in schools continues to increase and the number of children attending classes by health visitors has more than doubled. One middle school provided the health visitor with the opportunity to prepare a syllabus of health education throughout the entire school. All parents were invited on two evenings. The whole was a great success and accepted as part of future school curriculum."

The educationally subnormal schools also have a need for health education, as shown by Dr. Burn, Divisional Medical Officer (Horsforth):

"A new E.S.N. school has opened in the division and a health visitor arranged a programme to teach health to the pupils."

Increased liaison with hospital staff has extended health education into this field as noted by Dr. Douglas, Divisional Medical Officer (Spenborough):

"Health visitors and midwives continue to give talks and demonstrations with relaxation classes and this work has now extended to Staincliffe General Hospital where these classes are held in the evening."

Although we are in a period of uncertainty as to the future because of re-organisation of the local authority and health services, and much of this uncertainty is felt by those fully engaged in health education activities, the future of health education as a discipline is assured.

Each year the demand by the public and other professions for advice and help is increasing, almost to the point of outstripping our resources.

It is therefore essential that health education be co-ordinated, so that the expertise of scarce health personnel can be utilised in the most effective manner.

Renal Dialysis:

ADAPTATIONS TO PATIENTS' HOMES:

At 31st December, 1971, 45 cases had been referred to the West Riding County Council by the hospital authorities since the inception of the scheme. Twenty-four patients had been referred by the St. James's Hospital, Leeds (13 males, 11 females), 19 patients by the Lodge Moor Hospital, Sheffield (16 males, 3 females), 1 patient (male) by the Withington Hospital, Manchester, and 1 patient (female) by the Hull Royal Infirmary.

The 45 cases may be categorised as follows:

Died prior to starting adaptations...	4
Transplant prior to starting adaptations	2
Not suitable for home dialysis	2
Patients undergoing home dialysis	23
Adaptations in progress (includes also provision of portable units)	5
Transplant after adaptations had been completed	4
Died after adaptations had been completed	5
	45

Of the 23 patients undergoing home dialysis treatment, two patients—whose homes were not suitable for adaptations for dialysis purposes—were provided with a 'Portakabin'. Of the five patients due to commence home dialysis, two are to be supplied with a demountable portable unit.

PART IV

ENVIRONMENTAL HYGIENE

Food and Drugs

Sanitary Circumstances

See also Tables 51 to 58 of Appendix A and Appendix B

ENVIRONMENTAL HYGIENE

Food and Drugs Act, 1955:

THE MILK (SPECIAL DESIGNATION) REGULATIONS, 1963:

THE MILK (SPECIAL DESIGNATION) (AMENDMENT) REGULATIONS, 1965:

Licensed Dealers:

As anticipated in the last Report the number of dealers selling ultra heat treated milk has increased considerably since the installation of a processing plant in the Riding. Whether this type of milk will take the place of sterilised milk, which is still extremely popular as a 'shop' sold product, remains to be seen. There is no doubt that this milk is popular with campers and caravanners because of its unrefrigerated keeping life; and for people holidaying in country areas with the possibility of unsafe untreated supplies it could well be a wise buy.

The Health Department has tried continually to ensure that dealers received milk from approved suppliers and that cold storage facilities were available to them. The introduction of a voluntary Trade Code of Practice by the National Dairymen's Association on similar lines is welcomed.

Processing Plants:

Three pasteurising plants ceased operation during the year and one commenced. A number of enquiries regarding the installation of pasteurising plants is received each year from farmers who are worried about their retail milk sales if hit by brucellosis. The new plant mentioned above is one of those schemes which rarely materialise.

The number of phosphatase test failures is higher than last year but immediate follow-up action was taken in each case. It became necessary to prosecute one pasteuriser for failing this statutory test and only the closing down of another plant saved the licensee from similar action. In three other cases failures were due to the operation of plant by inexperienced staff and education was applied rather than punishment.

The plant mentioned last year, to produce ultra heat treated milk, came into commission during January. The milk has been of a consistently high standard with no test failure. As anticipated production has steadily increased and the plant is now in operation for much longer periods than originally.

The testing of washed bottles and churns has continued to show how necessary this surveillance is. This type of supervision really helps to keep dairies on their toes. Of 23 tests of washed bottles, six were not up to standard and 18 out of the 75 churn rinses examined were unsatisfactory. Dairies were keen to show good results on follow-up.

Premises Bottling Untreated Milk:

Regular visits of inspection and supervision were made to the 10 premises where untreated milk is purchased in bulk and then bottled. Of the 134 samples obtained 15 failed the methylene blue test. Investigations were instituted and appropriate action taken. On two occasions supplies had to be stopped because of positive cultures of brucellosis being found.

Supply of Milk to Schools:

Whilst efforts are made to ensure pasteurised milk supplies to schools a number still have to accept untreated supplies. Seventy-nine samples of untreated milk were obtained and submitted to the laboratory for examination for tuberculosis, brucellosis and antibiotics in addition to the methylene blue keeping quality test. One sample was positive for brucellosis, one for antibiotics and five samples failed the methylene blue test. Follow-up action was taken by the department except for the positive brucellosis result; this was dealt with by the divisional medical officer concerned.

During the latter part of the year it was found that following the cessation of free milk supplies to children over seven years of age, a number of head teachers and parents had organised private contracts to maintain supplies to the children. Immediate investigations were made of the sources of supply and in each case these were found to be previously approved suppliers.

Sampling of Milk at Hospital Farms:

Sampling, which is carried out at the request of the Department of Health and Social Security, continued at two farms. At Stanley Royd Hospital Farm, Wakefield, where the production of untreated milk takes place, 24 samples were obtained. All passed the methylene blue test. Although the milk is not used at the hospital in its raw state 12 of the samples were also submitted for examination for the presence of brucellosis and antibiotics. None of the samples was positive for either. At Stansfield View Hospital Farm, Todmorden, where milk is produced and pasteurised, 28 samples of pasteurised milk were obtained. Three samples failed the methylene blue test. As a check on production methods 15 samples of untreated milk were taken and none was unsatisfactory by the methylene blue test.

Antibiotics in Milk:

Two thousand three hundred and seventy-five samples were examined by the Wakefield Public Health Laboratory using the modified T.T.C. provisional method for the detection of antibiotic and other inhibitory substances in milk. Twenty-three samples were found to contain antibiotics and action was taken in co-operation with the Milk Marketing Board.

Brucellosis:

Two thousand three hundred and seventy-five samples were examined for the presence of brucellosis. All samples were submitted to the milk ring test and for cream culture where necessary. At the present time milk is being produced and sold from 802 herds in the Administrative County Area. During the year cream culture positive results were obtained from 93 of those herds at least once. The percentage of 11·6 is a welcome decrease on last years figure of 17 per cent. and it will be interesting to see whether the improvement can be maintained. Perhaps the effort being made nationally on both voluntary and compulsory eradication schemes is really now showing results. Additionally it would be interesting to know what the effect has been of the prohibition on the sale of infected animals, other than for slaughter.

The policy of notifying divisional medical officers of all results of milk samples taken by our staff has continued and grateful recognition is given to them and to the county district public health inspectors for their help and co-operation.

Our thanks go again to the Directors of the Public Health Laboratories in and around the county for the useful information they continue to send us. Wasteful duplication is thereby avoided. A special 'thank you' must go to Dr. L. A. Little, Director of the Public Health Laboratory, Wakefield, and his staff, for coping once again with all our samples and quite a few of our problems.

Qualitative Milk Sampling:

Under the County Council's scheme of qualitative milk sampling, 89 samples were submitted to the County Analyst by county district public health inspectors. Two samples were found to be deficient in fat on informal sampling but formal samples were satisfactory on follow-up.

Food Complaints:

Thirty-two complaints were received and investigated. A summary is given below of the details of each and the results where legal proceedings were taken. In other cases verbal or written cautions were given.

Insect in jar of plum jam.
Mould on fresh cream trifles.
Oily taint in bottles of school milk.
Hair in meat and potato pie.
Dirty milk bottle—3 cases.
Consignment of school milk badly bottled.
Cockroach in loaf of bread.
Sediment in bottle of milk.
Cigarette end in prawn chop suey—Prosecution, fine £20·00 with £16·14 costs.
Fly in bottle of fruit drink.
Fly in carton of milk.
Taint in butter.
Metal object in potato crisps.

Green discolouration in cream of coffee cream meringue.
Foreign body in bottle of school milk.
Cardboard in bottle of milk—Prosecution taken but case dismissed.
Mould on bread.
Tooth in Cornish pasty.
Glass in mineral water.
Sample of milk failed phosphatase test—Prosecution, fine £15·00 with £8·00 costs.
Foreign object in meat pie—2 cases.
Mould on fruit tarts.
Mouse dropping in loaf of bread.
Can of sago pudding with bitter taste.
Snail in bottle of milk.
Fly in bottle of milk.
Piece of paper in packet of sugar.
Piece of glass in slice of bread.
Dirt in tin of date pudding.

Water Supplies:

PLUMBO-SOLVENT WATER SUPPLIES:

The periodical examination of water from those public supplies in the West Riding which are known, or suspected, to possess plumbo-solvent properties has been carried out.

Two samples of water were collected from each supply (a) after standing all night and (b) after standing for 30 minutes in a lead service pipe, and the samples were examined for the presence of lead. Two hundred and thirty-two samples were examined and in each case the result of the examination was notified to the medical officer of health and other appropriate officers of the county district concerned.

During the year new W.H.O. International Standards for Drinking Water were issued which now give 0·10 mg/l as the maximum allowable concentration of lead. Up to the year end, however, all results above 0·05 mg/l were being notified to the respective authorities as unsatisfactory in the hope that efforts would be made to achieve this higher standard.

PRIVATE SUPPLIES OF WATER TO COUNTY PREMISES:

Supervision and sampling has continued of these private water supplies. Two hundred samples were taken of which 45 required some follow-up action.

FLUORIDATION OF WATER SUPPLIES:

Only slight progress towards achieving fluoridation of the water supplies has been made.

Previous Reports have reviewed the scheme at Reva Reservoir, Hawksworth; this operated satisfactorily for most of the year and 53 water samples were taken by members of our staff and examined within the department for fluoride content. All were within acceptable limits except seven taken during April when a breakdown in the fluoridation plant occurred and these were below the optimum level. The equipment 'failed safe' and for a period of three weeks fluoridation was suspended. The breakdown was rectified early in May since when no untoward incident has arisen.

In August, 1970, Huddersfield Corporation introduced fluoridated water to part of the Borough, to Golcar in Colne Valley U.D., and to a lesser extent in parts of Mirfield U.D. In the initial stages only slightly fluoridated water was supplied to the parts of the Administrative County; this was overcome in the Golcar area when modernisation of the Borough's treatment plant at Scapegoat Hill was completed and fluoridation commenced at the optimum level on 1st May, 1972. As the proposed modernisation of other plant proceeds during the next two or three years it is expected that schemes will extend fluoridation throughout the Borough's limits of supply.

At the year-end the introduction of fluoridation by Bradford Corporation at Addingham had not been effected. However, installation of the fluoridation unit has been completed and, following various minor adjustments to the plant including the improvement in accuracy of an associated flow measurement unit, fluoridation commenced on 1st June, 1972.

In pursuance of the County Council's policy, negotiations have proceeded with Bradford Corporation for the fluoridation of the water supplied by their undertaking in Silsden U.D. Modernisation of the plant involved is currently taking place and at the time of writing (June, 1972) an agreement is being formulated.

Rural Water Supplies and Sewerage Acts, 1944-61:

All schemes submitted for grant were examined and comments forwarded to County Planning Officer for onward transmission, with his observations, to the County Council's Consulting Engineer.

In addition, Ministry Inquiries and Investigations of Schemes were attended where held.

Local Government Act, 1958, Section 56:

SEWERAGE SCHEMES—APPLICATIONS FOR GRANTS:

No application was received during the year.

School Swimming Pools:

Details of the 67 swimming pools in operation and under construction are given in Table 57.

One thousand four hundred and seventy-four water samples were obtained and submitted to the Wakefield Public Health Laboratory for bacteriological and chemical testing. In addition to sampling, advice was given to pool operators on water sterilisation and on the operation and maintenance of water treatment plant generally. Sampling was also carried out at the Woodhall Centre, Wetherby, and Hilton Grange Children's Home, Bramhope, although these are not County establishments.

Caravan Sites Act, 1968:

GYPSIES:

At the time of writing the site at Baildon is under construction and should be open in 1972. The standard of facilities to be provided are such as to make it hard to believe that anyone stopping there will wish to move on.

Plans are being drawn up for the second site, within Kiveton Park Rural District, and it is hoped to report some real progress next year.

Progress has been slow on any other site although meetings with interested parties have continued.

Pharmacy and Poisons Act, 1933:

Two hundred and eighty-five visits of inspection were made to premises listed for the sale of Part II poisons.

Tetanus Survey:

The collection of soil samples for a long-term survey of the antibiotic resistance of strains of *Clostridium tetani* has continued. The survey is being undertaken by the Public Health Laboratory Service.

Riding Establishments Act, 1964:

Premises licensed by the County Council were visited at least once each. The general public health aspects of each establishment were examined and a report submitted to the Clerk of the County Council. This report is considered along with reports of a veterinary surgeon and the County Fire Officer before a licence is issued.

Atmospheric Pollution:

The Authority's scheme for the measurement of atmospheric pollution, operated in conjunction with the Warren Spring Laboratory of the Department of Trade and Industry and Officers of the County Districts, has continued efficiently.

At the year-end 39 district councils were participating involving 52 combined daily smoke filter and sulphur dioxide instruments, and four daily smoke filters only.

PART V

MISCELLANEOUS

Persons in need of Care and Attention

Registration of Nursing Homes

Notification of Births

Medical Arrangements for County Children's Homes and Residential Nurseries

Road Traffic Act, 1960

Medical Examination

West Riding Distress Fund

See also Tables 59 to 60 of Appendix A

REMOVAL TO SUITABLE PREMISES OF PERSONS IN NEED OF CARE AND ATTENTION

Section 47 of the *National Assistance Act*, 1948, and the *National Assistance (Amendment) Act, 1951*, which provide for the compulsory removal to appropriate accommodation of persons requiring care and attention, had to be instituted in eight cases, all women: three were admitted to hospital and five to Part III accommodation.

REGISTRATION OF NURSING HOMES

There were two amended registrations and one cancellation of registration during the year under the provisions of the *Public Health Act, 1936*, as amended by the *Nursing Homes Act, 1963*.

NOTIFICATION OF BIRTHS

(*Public Health Act, 1936, Section 203*)

The number of live and still births notified and attributable to the County area was 31,086. When this figure is compared with the Registrar General's return of 31,069 births (30,687 live and 382 still births), the degree of error is small and affords satisfactory evidence of the system of notification. Prompt notification makes it possible to arrange for early visiting of babies by health visitors and it is satisfying to record that 30,487 first visits to children born in 1971 were made.

MEDICAL ARRANGEMENTS FOR COUNTY CHILDREN'S HOMES AND RESIDENTIAL NURSERIES

Divisional Medical Officers have submitted periodic reports on the discharge of their responsibilities for the medical arrangements at County Children's Homes and Residential Nurseries; these provide for the medical examination of children on admission and discharge, subsequent routine and special examinations, the keeping of medical records, precautions against the spread of infectious diseases, determining the hours of rest and sleep, the general supervision of health, hygiene and diet, and the staffing of the nurseries. Routine examinations, which are undertaken monthly in residential nurseries and six-monthly in children's homes, reveal the not-unexpected high proportion of children with physical and mental defects and with emotional problems.

ROAD TRAFFIC ACT, 1960—SECTION 100(6)

The number of cases (265 compared with 263 in 1970) referred by the Clerk of the County Council for advice with regard to their medical fitness to hold driving licences has remained at the level to which it rose following the introduction of the new regulations concerning persons suffering from epilepsy which came into operation on the 1st June, 1970. Enquiries and investigations were carried out and appropriate recommendations passed to the Clerk for the guidance of the Local Taxation Officer.

Medical fitness to hold a driving licence was reviewed in 93 cases and in none of these was it found necessary to recommend a revocation of the licence. The family doctors and specialists concerned with these cases continue to be helpful and co-operate when asked for information about patients. Consultant's opinions were obtained in 55 cases.

Reason for referral	Number of cases	Number who received driving licence
Epilepsy	172 (148)	126 (123)
Diabetes	5 (5)	3 (4)
Cardiovascular disease	16 (10)	13 (9)
Other disorders of consciousness ...	43 (30)	36 (24)
Vision defects	2 (2)	— (—)
Other physical disabilities	14 (46)	13 (43)
Mental illness or subnormality	8 (21)	7 (18)
Other	5 (1)	3 (—)
Totals ...	265 (263)	201 (221)

(1970 figures shown in brackets)

MEDICAL EXAMINATION

The number of persons being considered for admission to the County Council's superannuation scheme, either as new appointments or after two years' service as manual workers, has continued to rise, the total, 2,422, being an increase of 196 over the previous year. Medical examinations were required on 766 cases: 1,656 persons were admitted to the Scheme on the basis of the information contained in the Health Questionnaire. The reasons for the referral for medical examination were:

	Number referred		Approved		Not Approved		Decision Deferred	
Age	123	(159)	116	(140)	3	(10)	4	(9)
History	413	(363)	373	(318)	19	(17)	21	(28)
Category of employment (i.e., driver)	117	(102)	114	(93)	2	(3)	1	(6)
Age and History	89	(53)	56	(38)	18	(5)	15	(10)
Age and Category	11	(11)	11	(9)	—	(2)	—	(—)
History and Category	10	(7)	8	(7)	2	(—)	—	(—)
Age, History and Category	3	(1)	2	(1)	—	(—)	1	(—)
Totals ...	766	(696)	680	(606)	44	(37)	42	(53)

(1970 figures shown in brackets)

These examinations have been carried out by the County Council's medical officers and general practitioners employed on a sessional basis. In addition, 25 (24) examinations have been carried out at the request of other local authorities. Re-examinations have been carried out in 31 cases where the decision was

previously deferred. Of these 12 were approved, nine were regarded as unfit for admission to the Superannuation Scheme and 10 were deferred for another examination at a later date. Special medical examinations have been undertaken in respect of 135 (160) employees in the various departments who have had lengthy periods of sickness absence.

WEST RIDING DISTRESS FUND

Assistance from the West Riding Distress Fund was made available to provide clothing for a mentally handicapped man whose family was in poor financial circumstances.

PART VI

THE HEALTH OF THE SCHOOL CHILD

The Annual Report of the Principal School Medical Officer

including

The Report of the Principal School Dental Officer

See also Tables 61 to 72 of Appendix A and Appendix C

THE HEALTH OF THE SCHOOL CHILD

(Being the 64th Annual Report of the Principal School Medical Officer)

Introduction:

Whilst the future of the School Health Service has not yet been decided and further discussions continue there is an increasing awareness amongst those concerned with child health that the present local authority clinical medical officer will have much to offer in the care of the handicapped child within the community in the future pattern of the medical services. Pædiatricians within the hospital situation increasingly seek the help of the local authority staff in many areas in the assessment of the handicapped child.

New recruitment of medical staff is still somewhat limited but this is not due entirely to uncertainty about the future. Financial differentiations in the various branches of the health services also have an effect. During 1971 four new whole-time departmental medical officers were appointed and further appointments were also made to the permanent part-time staff. There are now 15 medical officers working on a permanent part-time basis. Whilst recruitment of staff has been greater than losses by retirement or resignation there are several areas in the West Riding where the shortage of medical staff creates local problems. This particularly applies in the industrial areas east of Wakefield.

The medical journals often carry letters from women doctors stressing their difficulties in obtaining suitable employment especially when they have domestic commitments. The present composition of the clinical medical staff in the Divisions is of interest. Of the 32 whole-time staff, 11 are men and 21 women—14 of the women being married. The 15 permanent part-time staff comprise two men and 13 women: 12 of the women being married. With the County Council's policy of seconding staff on in-service training courses all the medical staff have received training in the various aspects of developmental assessments and the ascertainment of handicapped children. Married women are often unable to attend residential courses at some distance from their homes. This problem has been overcome to a great extent by day release courses at County Headquarters and secondment to short courses in the region. These include the courses on audiology at Manchester University, courses sponsored by the Society of Medical Officers of Health and, in 1971 a very successful week-end course was held at Leeds on emotional problems of childhood—arranged by the N.A.M.H.; Dr. Simpson Smith acted as course tutor. The idea that women doctors in the Service can only be engaged on routine duties is therefore invalid. With training they can become specialized in the various branches of child health and without them it would be impossible to maintain the present services.

It is hoped that forthcoming changes will create a career structure for doctors wishing to work in the clinical field of community child health. The relatively small proportion of male doctors on the staff does not, in itself, show the full picture. Only one is below middle age. A recent advertisement for a Senior Departmental Medical Officer (Clinical) in the national medical journals resulted in one enquiry only which was not followed up. This is typical of national experience.

One of the perennial difficulties is the shortage of speech therapists in many areas. Recruitment frequently depends on married therapists coming to live in the County and resignations result from family commitments. Every effort is made to recruit therapists on qualification but the service is extremely limited or non-existent in some districts. This is not a purely local problem.

Following the decision of the appropriate committee in 1970 to increase the complement of psychologists to 18 a further five whole-time and one part-time appointments were made in 1971 so that on 1st January, 1972, there were 16 psychologists in post, three being part-time or sessional appointments. It is anticipated that further recruitment will take place during 1972 to the equivalent of 18 whole-time personnel. This is considerably less than the figure of one psychologist to 10,000 school children suggested by the Summerfield Report although it was pointed out that availability of staff would not be sufficient to achieve this figure in the 1970s. The present staffing position is certainly an improvement on the one psychologist appointed to the West Riding in 1956 later increased to two until 1964. The increase in staff has enabled some re-allocation of duties and a specific attachment of psychologists to special schools and remedial centres. The work continues to increase particularly as more interest is being taken in the re-assessment of handicapped children and in screening procedures within the ordinary schools to pick out children at risk of educational failure or maladjustment.

The future of the Child Guidance Service is still in some doubt. The National Union of Teachers strongly believes that the service should be within the Educational orbit whilst the Society of Medical Officers of Health equally firmly considers that the Child Guidance Service should become part of the general health service in 1974. In the meantime a further post of Senior Medical Officer in Psychiatry was filled during 1971 by Dr. Sanderson. This has enabled more help to be given to the assessment centres of the Social Services Department, both Dr. Read and Dr. Sanderson having a specific allocation of time for the centres as well as the psychologists.

The close liaison between the Health and Education Departments in the West Riding continues with a multiplicity of joint meetings and case conferences. The transfer of the training centres for the subnormal to the Education Committee on April 1st, 1971, presented specific problems which had to be overcome and links are being forged between the two Departments and the Social Services Department to ensure that a team approach will be of benefit to any handicapped child.

Liaison between the Education Department and the School Health Services was demonstrated in a concrete form during the year by the publication of a pamphlet *Children with Special Educational Needs*. The suggestion for such a publication came from Sir Alec Clegg and the joint authors were Dr. Simpson Smith and Mr. J. G. Millard—the County's Adviser on Special Education. The aim was to provide teachers with an outline of the educational and medical

reasons for possible educational failure and to suggest ways of overcoming the problems. The pamphlet has been reviewed widely and well received. Before this report is published Mr. Millard will have retired from the County Service and one must pay tribute to his tremendous efforts in furthering the aim of a team spirit between the departments during his time in the West Riding as well as his advice in regard to *Well-being* the periodic joint publication of the two Departments.

The extended use of the computer is showing its effect on the more efficient follow-up of children with handicaps and defects. The computer is often blamed for mistakes when, in fact, the human element has crept in. It has not become our master but is a very valuable help.

Once again I wish to express my appreciation to the staff of all departments concerned with the health of the child for helping to extend the services provided and to improve the efficiency of the care of the handicapped child. 1971 has not been a year of standstill and I look forward to further developments in the service during 1972.

Care of Handicapped Children:

THE MENTALLY SUBNORMAL:

The major change during 1971 was the transfer of the care of the severely retarded child to the Education Committee on 1st April. All children are now regarded as 'educable' and the former training centres for children are special schools. Most of the problems of the transfer came within the purview of the Education Department. Since the transfer, changes are being made to bring the number of staff and the facilities into line with other educational provision. A particular difficulty was that although under the *Mental Health Act, 1959*, the Authority could demand attendance at a training centre the West Riding Health Committee had never insisted on compulsory attendance against the parents' wishes. Consequently on 1st April it was found that a considerable number of severely retarded children were at home and not receiving any form of training. Under the *Education Act, 1944*, the child must receive education when of school age. Parents have had to be approached tactfully but some of the previous resentment of training centres has been overcome now that they are designated as schools.

At the same date the former Mental Welfare Officers who had been of considerable help in liaison between the home, the centre, and the medical services were transferred to the Social Services Department becoming 'generic' social workers. In several Divisions a temporary set-back inevitably occurred but the Education Welfare Officers took over a new role. However, through taking an active part in the case conferences now held at all the former training centres and attendance on in-service courses, the value of their work in this new field is already becoming apparent. The case conferences at the schools are attended by represent-

atives of the Health and Education Departments both centrally and divisionally and a representative of the Social Services Department is to be invited from January, 1972. Administratively the admission to the schools is now arranged by the Special Services Department of the Education Authority where formerly the Divisional Medical Officer was responsible. The same medical staff continue to provide oversight at the schools so there has been continuity of medical supervision.

The conferences should help to overcome various other difficulties which have arisen since the former junior centres were transferred to the Education Committee and the adult centres became the responsibility of the Social Services Department. Severely physically and mentally handicapped individuals attend the special care units at the schools. In the past several remained when of adult age as other facilities for day care were not available. As the Education Authority can only be responsible and provide education up to the age of 19 years alternative arrangements will have to be made by the Social Services Department over this age. The situation is under constant review. In general it is not advisable, in any event, to have adult incontinent and handicapped persons in the same environment as children from the age of 2-3 years. Most of the centres were comprehensive in nature in the West Riding and adolescents were able to transfer gradually from the junior to senior sections via a transitional class—spending some time in each department. Since the changes on April 1st there has been a tendency in some areas to a more rigid pattern of admission to the adult centres. It is hoped that this is only a temporary phase until more staff and accommodation become available as there were many advantages in the former system. Here again a co-operative team approach is essential to the welfare of these handicapped young persons.

Many fears were expressed when the *Education (Handicapped Children) Act, 1970*, became operative. Teachers felt untrained for the approach required to the more retarded child although they felt that an 'educational 'approach rather than that of 'training' might have considerable benefits for the children. National and local in-service training courses are helping to give guide lines. It was also feared that parents would expect miracles overnight but so far this has not been demonstrated and indicates that the majority of parents have a considerable degree of insight into the limitations of their handicapped children. The May, 1971, issue of *Well-being* paid special attention to various aspects of the transfer and made the point that there is a fundamental difference between the category of pupils 'educationally subnormal' and the more severely retarded group—the latter having a high proportion of children with associated physical problems.

Children with Impaired Hearing:

The value of the work of the three peripatetic teachers of the deaf in some areas of the County has been well established and it is hoped that the service will be extended further during 1972. At a newly opened school for educationally subnormal patients the peripatetic teacher discovered a high proportion of children with significant hearing loss which might have a bearing on their attainments. The children concerned will all be investigated further.

THE PHYSICALLY HANDICAPPED CHILD:

The problems created by the increasing survival rate of severely handicapped children due to the condition spina bifida cystica have been referred to previously. Some of these children are now of school leaving age and better facilities are needed for further education and training as handicapped persons as also for care when the parents are unable to look after them at home. The *Chronically Sick and Disabled Persons Act, 1970*, has resulted in discussions and surveys in the various regions in which local authorities and Regional Hospital Boards have co-operated.

Ophthalmic Clinics:

From the inception of the National Health Service in 1948 the Regional Hospital Boards became responsible for the employment of the ophthalmologists in charge of the local authority's eye clinics and former staff employed by the authority were transferred. The last of the doctors transferred to the Regional Hospital Board, Dr. L. Wittels, retired in 1971 and several of his clinics were not being covered by a successor at the end of the year. His retirement has aggravated a situation which has been increasing in recent years and there are several areas of the West Riding where the clinics have had to be closed temporarily.

Various discussions have taken place with the Leeds Regional Hospital Board and the local Hospital Management Committees have been asked to stimulate recruitment where possible. Unfortunately there is a general shortage of consultant ophthalmologists and most of the time of those available is taken up within the hospital situation.

The local authority clinic has the advantage for parents and children that attendance often avoids the need for long journeys to hospital out-patients' departments. As the nursing staff from the authority attend the clinics this assists follow-up to ensure that spectacles have been obtained when prescribed.

The view is still firmly held in medical circles and especially by the ophthalmologists themselves that any child with a possible visual handicap should be seen initially by trained medical staff rather than referred directly to an optician for refraction. This is to eliminate the possibility of other medical conditions affecting the sight.

In an endeavour to provide medical oversight at clinics where the hospital services have been unable to provide staff, departmental medical officers have been encouraged to go for training at Leeds if interested. Two members of the staff have been able to run the clinics in their areas as a result and a further doctor is to receive training shortly. At the end of 1971 there were waiting lists of children which adversely affected reviews in several areas and no clinics were being operated in the following Health Divisions: Goole, Castleford and Colne Valley—all within the Leeds Regional Hospital Board area.

The Maladjusted Child:

Shortage of psychiatric social workers is still very acute in most areas of the West Riding and little recruitment has been possible as the national salary scales compare unfavourably with grades in the Social Services Departments. This affects the work of the Child Guidance Clinics.

It is hoped that the opening of a new school for maladjusted boys in the West Riding during 1972 and a school for girls in the Dewsbury C.B. will help to reduce the size of the waiting lists for placement.

The approach to emotional problems of school life should have the main emphasis on prevention. Periodic assessments and early recognition of educational failure should help to prevent a child becoming frankly maladjusted.

Co-ordination of In-Service Training and Attachment of Medical Staff:

Previous Annual Reports have referred to the policy of in-service training of medical officers and the courses arranged in recent years at County Headquarters. From 1971, following a committee decision, it has been possible to pay travelling expenses for family doctors doing sessional work but not under contract with the authority to attend the short courses on developmental assessments. A limited number have availed themselves of this facility and it is worth reporting that the Dean of Post-graduate Medicine at Leeds University has now recognised the courses as part of training for doctors in their entitlement to post-graduate allowance and/or seniority allowance.

As has been mentioned elsewhere in this Report a large proportion of the medical staff are married women with domestic commitments who cannot be away from home for long periods to attend courses in centres such as London. This has been largely overcome by short courses held locally and by the fact that a course has been held almost annually at Leeds on the ascertainment of the mentally handicapped child. However, it has not been possible to second staff on such courses as a six weeks' whole time study of Child Development organized by the Society of Medical Officers of Health. Apart from other factors the cost to the authority of seconding one person was very high. After due consideration it was decided to hold a one-day per week course for experienced medical officers and such a course was held from October, 1968 to July, 1969 at Wakefield. The syllabus included much of the content of the Society's six week course but also included other topics of interest to the staff. This was well received and was repeated in the following year on a shorter basis for more recently appointed staff. In the last two years the main courses held have been concerned with developmental assessments in view of the change in pattern of the child health services for the pre-school child. All the present staff, apart from very recent appointments awaiting training, have now attended courses of in-service training on child development and the ascertainment of mental handicaps and are therefore able to specialize in this aspect of work with children.

At national level a working party was set up in 1970 to consider the rationalisation of the various courses being held. Dr. Francis was a member. It was generally agreed that there was an important need for a course of training for doctors who will specialise in what is broadly called 'community pædiatrics'. It was felt that the various separate courses could not stand separately and it was suggested that new integrated courses should be provided both in London and at provincial centres based on University Departments. It was also considered that new courses should be broadened to include the various problems of all handicapped children so that they would provide vocational training for those wanting to take up a professional career with handicapped children.

The need to continue the training of medical officers to undertake detailed intelligence testing has also been under review by the Department of Education and Science. Whilst it is felt that the doctors should be familiar with all testing procedures it is considered that, in general, there should be in the future sufficient psychologists to undertake the testing itself leaving the medical staff more time for neurological and psychiatric examinations and general counselling on the child's future as a whole rather than making what is, to a great extent, an educational decision.

With this background in mind detailed discussions have taken place between Professor R. W. Smithells, of the Department of Pædiatrics and Child Health, University of Leeds and medical representatives of the Department of Preventive Medicine and Public Health, University of Leeds, the Department of Education and Science and the Public Health Departments of Leeds County Borough and the West Riding County Council. The experience gained from the earlier courses held in the West Riding formed a basis for an outline of a proposed course and, after various meetings, a draft syllabus was drawn up. The course has been approved by the Board of the Faculty of Medicine of the University and by the Department of Education and Science. It is hoped that the first course will be held during 1972. It has been agreed that Dr. Simpson Smith should be one of the tutors.

Under the general heading of 'Developmental Pædiatrics' the course is divided into three terms. Each term will begin with one week whole-time attendance when the main theme for the term is outlined. The main themes are: Child Development and the Detection of Defects; The Child with Handicapping Defects and The Child with Mental and Emotional Problems. Thereafter there will be day-release studies of the individual aspects in depth. It is intended that both local authority staff and hospital medical staff should attend and there will be some division of the course to enable each group to obtain practical experience in aspects with which they are not familiar.

The aim of the course is to provide the necessary vocational training for the future 'community pædiatricians' and forge closer links between the present local authority and hospital staffs before 1974 arrives.

In this context also there have been interesting developments in the sphere of co-operation. After discussion in Sheffield, Dr. Merry, a Senior Clinical Medical Officer, has now a formal attachment for one half-day per week to the Ryegate Centre for Handicapped Children. It is hoped when the planned comprehensive assessment centres for handicapped children are set up at hospitals within the area that further attachment of local authority staff will take place thus helping to co-ordinate the medical aspects with the educational needs of the child. In various areas medical officers already attend ward rounds and case conferences in the hospital pædiatric departments.

All these developments are already bringing together the hospital and local authority medical officers so that a team spirit is developing in the care of the handicapped child thus paving the way for the integration of the Services in 1974.

The Work of the Psychiatrists:

Dr. Elizabeth Gore reports as follows on the operation of the Child Guidance Clinic at Harrogate:

"In 1971, 127 cases were seen—89 boys and 38 girls. 116 of these cases were referred from Division 7 as follows:

	Boys	Girls	Total
Divisional Medical Officer ...	21	13	34
General Practitioners	16	6	22
Head Teachers	16	4	20
Parents	7	6	13
Pædiatrician	13	5	18
Others	6	3	9
	79	37	116

The total of new cases referred in Division 7 shows an increase of 15 over the year, with a relative increase in the number of girls. A very much larger number of cases was referred to the clinic from the Pædiatrician, but these except for two cases, were referred for advice only. There was also an increase in the number of cases referred from General Practitioners.

Mr. Popplewell took up his appointment as Remedial Teacher in January. He has continued and developed the work in the morning play therapy group, with slightly bigger numbers. It is a matter of great concern that this work, which we consider so valuable in saving children being recommended for residential placement, must, apparently, be discontinued after Easter because the premises now being used will no longer be available and no alternative accommodation can be found. During the year the Social Services Department was being developed and we are glad to feel that we have a fruitful and close relationship with the department in Harrogate. Mutual discussions have helped to prevent duplication of work for both sides, and we have also been able in a

number of instances to hand over cases and families for supervision by the Social Services Department, where this was more appropriate. We have also found the Department helpful in cases where the children are away at school.

This has meant that we have had more time to work with the other children and their families. But in addition the development of the school counselling system and a closer co-operation with the Educational Welfare Department, has also meant that where suitable they have been able to deal in whole or in part with children, with whom we might otherwise have been heavily involved.

These contacts have been in addition to the ones already established with health visitors, headteachers and a number of the family doctors. Most important perhaps has been the continued close contact with Dr. Hepple and his medical officers.

We have continued to have social work students from Leeds, from the West Riding and also students taking their Diploma in Primary Education from Leeds University and a number of others."

Reporting on the Child Guidance Clinics at Mirfield, Pontefract, Ossett and Morley, Dr. Maxwell states:

"In 1971 I gave up the Ossett Clinic and was replaced by Dr. Hilary Sanderson in order to provide the very necessary full day weekly at the Morley Clinic. At the Mirfield Clinic Mrs. Rose Bindman resigned from her duties as Social Worker after many years in that clinic. Mr. Derek Clark, Psychologist, commenced work at the Pontefract Clinic during the year.

As in previous years teaching of associated staff has been carried out in these clinics and lectures have been given to interested organisations in the areas. In the Autumn a talk was given at Batley Town Hall by members of the Mirfield clinic team to a large group consisting of members of the Magistrates' Panels, the subject being the work of the Child Guidance Service, and this was especially well received.

Members of the public health medical staff have taken an interest in the clinics, attending frequently and we have had occasional welcome visits from general practitioners in the clinic areas.

The clinic figures are as follows:

Table 1

	Mirfield	*Ponte-fract*	*Ossett*	*Morley*	*Total*
No. of sessions held... ...	192	101	75	73	441
No. of new cases	160	86	53	46	345
No. of cases continuing attendance from previous years	116	51	48	53	268
No. of cases closed during 1971	168	79	43	39	329
No. of cases carried forward to 1972	108	58	58	60	284

Table 2

Clinic	*Number of New Cases*							
	1964	*1965*	*1966*	*1967*	*1968*	*1969*	*1970*	*1971*
Mirfield ...	115	106	104	165	164	161	154	160
Pontefract ...	75	67	41	74	74	88	69	86
Ossett ...	9	15	20	17	24	28	40	33 (to 29-7-71)
Morley ...	10	19	31	32	32	40	47	46
Rothwell ...	27	37	28 (to 7-10-66)	—	—	—	—	—
Total ...	236	244	224	288	294	317	310	325"

Dr. Orme, consultant psychiatrist at the Swinton, Barnsley and Ecclesfield clinics reports as follows:

"A year ago I wrote '1970 has been an exciting year at the Swinton Clinic' because a full staff had enabled children to be seen, treatments to be carried out and communications opened with other agencies in a way which fulfilled the role expected of a child guidance clinic. 1971 gives a very different picture because of the changes in the social work sphere. The Psychiatric Social Worker, Mr. D. Pottage, left to join the Social Services Department; the Social Worker, Mrs. P. Collins, left to go on a course; and the trainee Social Worker, Miss P. Frankish, had to be transferred largely to other clinics. Thus from 12 social work sessions per week in the clinic and six to ten sessions for home visiting in 1970, we only had two in the clinic with none free for home visits during the last few months of 1971. This resulted in a dramatic fall in the number of new cases seen and an even greater fall in the degree of care given to the individual cases. This was also a marked vindication for the recommendations in the Underwood Report of 1956 that three social worker sessions are needed for every psychiatrist's session. Without these, effectiveness of the clinic is very greatly diminished. Despite increasing knowledge and skill in understanding children's disturbances we have made few advances in treatment which still needs careful and extensive discussion of emotional reactions of both children and their parents.

However, the situation at Swinton has not been quite so gloomy as the Divisional Social Services Officer has been able to give a little assistance—two social workers who are each working one session in alternate weeks in the clinic. This brings the total social worker sessions to three a week—roughly a sixth of the time at the beginning of the year. Having new workers also emphasises how important the team approach is and that this is only possible after a considerable period of working together and gaining understanding of different methods. At Ecclesfield the social worker has remained in the clinic though transferring to Social Services Department. At Barnsley there has been no replacement for Mrs. Collins so help to the parents is being given by psychologist and psychiatrist. The short time available, however, creates an added difficulty.

The experiences of this year have shown how important it is to have adequate social workers in the clinic and also how it takes time and care to create the team which alone can give satisfactory treatment for many of the behaviour and emotional disturbances seen in the children referred."

Dr. Hilary Sanderson reports as follows on the operation of the Hemsworth, Ossett, Rothwell and Tadcaster Child Guidance Clinics:

"At Rothwell, Hemsworth, Tadcaster and Ossett Clinics there were several changes of staff during the summer and I have been very pleased to welcome Mrs. Gillibrand, Mr. Clark and Mr. Mannix as Psychologists, and Mrs. Kinch as Social Worker in the Rothwell/Wetherby Division.

We were sorry to lose Mrs. Adams, Psychiatric Social Worker at Tadcaster, but hope this may only be for a limited period.

With the consistent and willing help of the social workers, two student psychiatric social workers, and two student teachers from St. John's Training College, York, we have been able to continue the weekly play group for disturbed children at Tadcaster on Thursday afternoons. We feel this has been extremely useful for observation purposes, to make better relationships with the children, and in treatment helping the child socialise and gain independence from the mother.

The lunch-time meetings of medical and social workers in various fields, held monthly at Hemsworth, have provided opportunity for discussing individual children and the pooling of information. Pyramid meetings in this Division serve a similar function.

The interest and willingness to discuss specific children, even including visits to the clinic by headteachers, provides an invaluable liaison.

I would like to take this opportunity of thanking workers in associated fields, including clerical staff, for their willing help and co-operation."

The Work of the Psychologists:

There were four new appointments in 1971 which brought the number of psychologists in the service to 14 by the end of the year, three being part-time. The psychologists are now working with handicapped, maladjusted and deprived children of all ages, in the child guidance and special clinics, the schools, special schools and remedial centres, and in the assessment centres which are the responsibility of the Social Services Department. The Summerfield Committee recommendation in 1968, that local authorities should aim at employing one psychologist for 10,000 school children, would imply a doubling of the present establishment in the West Riding; and subsequent legislation regarding the special education of severely subnormal children and the assessment of children coming into care has brought additional work.

The figures given in the Appendix provide details of the main areas of work and indicate some points of growth in the service. The total number of children seen for individual examinations in 1971 was 2,285. About one child in 140 of school age in the West Riding was examined by a psychologist in the year. This is not a large proportion when account is taken of the incidence of handicaps and difficulties of various kinds which affect the progress of children and in which psychological features are important.

Of the children examined, 872 were children who had been referred for investigation and treatment in child guidance clinics. The psychologists saw 1,413 children with handicaps and difficulties referred principally for educational psychological assessment and guidance.

Psychological work in the schools increased considerably, 1,129 visits being made to ordinary schools, and 206 visits to the special schools. There was a continuance of screening surveys of primary school children with the purpose of identifying children in need of further attention for emotional, behaviour and learning difficulties. Assistance was also given on request with the internal selection of children for extra remedial attention in some schools.

Five of the psychologists were eventually available for work in the three assessment centres, to which 173 visits were made. Two psychologists continued to work in the audiology clinics. Several children, mainly very young and severely handicapped, were examined in their own homes, 138 home visits being made.

CHILD GUIDANCE:

The psychologists continued to be based on the child guidance clinics and to work as members of the clinic teams. It has become easier to recruit psychologists than other child guidance staff, of whom there is a serious national shortage; and it is generally recognised that child guidance services are seldom adequately staffed to meet the potential demand.

Estimates of maladjustment in the school population far exceed the numbers of children who can be seen in child guidance clinics; and this is confirmed by the figures produced by the survey which has continued in the primary schools of one of the Divisions.

The information we have regarding the 872 children examined by the psychologists as part of the child guidance investigation relates only to the main problems for which they were referred, classified according to the categories first suggested by the Underwood Report, and to the ages at which they were first seen in the clinics. Classification is somewhat arbitrary owing to the numbers of children with 'mixed' symptoms. But about two-thirds of these children had been referred mainly because their behaviour was creating social and management problems at home or at school; and about a third were suffering from nervous conditions, such as fears, phobias, timidity and symptoms of a physical and tensional kind. The high proportion of behaviour problems, often associated with educational retardation, is probably typical of the 'case load' in local authority clinics.

Children of pre-school age accounted for four per cent. of the children seen in the child guidance clinics. Fifty three per cent. came within the age range 5 to 10+ years; and in this age group there were 347 boys and only 117 girls, which suggests that boys are about three times more likely than girls to be referred for child psychiatric attention during the primary school period. The proportion of girls increases over the age of 11 years.

Children with Handicaps Other Than Maladjustment:

More time is now being spent by the psychologists in examining children with specific handicaps and educational problems.

Work with pre-school handicapped children has always been a feature of the psychologists' work in the West Riding, and it can be expected to increase with the emphasis now being placed on early screening procedures conducted by the health visitors and school medical officers. There is also a steady number of referrals of young handicapped children to the psychologists from hospital pædiatricians in some areas of the Riding.

The psychologists are particularly called upon to examine children with serious intellectual limitations, and this is reflected in the large number of children, 485 in all, who were found to be generally backward, many of them being severely subnormal. Increasing involvement with the schools has, however, been bringing greater numbers of children for psychological assessment of specific learning difficulties, the number this year being 540. These are mostly children who have difficulties in learning to read, although their abilities in other respects are normal; and it is of interest that this group included 429 boys but only 111 girls. It is this aspect of work, closely linked with the schools and remedial centres, which has been developing most rapidly and in which requests for assistance are likely to increase.

An extension of screening procedures could be beneficial in detecting children with educational and related problems fairly early in their school career.

Children Seen In Assessment Centres:

It has been requested that all children who are admitted to the assessment centres should be given a psychological examination. These are generally deprived children, with disturbing backgrounds, many of whom have been in trouble or committed offences, and presenting problems very similar to those found in children attending child guidance clinics, including a high incidence of educational retardation. The work also brings the psychologists into contact with young people who have left school and been in employment prior to their committal to care.

The number of children seen by the psychologists in the assessment centres in the year was 186, 143 being boys and 43 girls.

SUMMARY:

A psychological service is now available for assistance with the whole range of problems in children, but it is still thinly spread in relation to the child population of the West Riding. With increasing staff over the past few years it has become possible to undertake more work in the schools and special schools, and this has been the main development, with no diminution in the part played by the psychologists in the diagnostic and treatment work of the child guidance clinics. A contribution has also started to the work of the social services for children through the attachments to the assessment centres.

Consultant Cardiac Clinic:

Dr. Hepple reports as follows on the Cardiac Clinic at Harrogate:

"During 1971 a total of 11 sessions of the Cardiac Clinic were held, when 109 children made a total of 115 attendances. There were 15 new cases referred to the Cardiac Clinic, but these were children found to have heart defects at routine school medical examination. It is now the practice for infants with heart defects to be seen at the Pædiatric Clinic at Harrogate General Hospital and, with the inevitable discharge of older children and no 'intake' of babies, Cardiac Clinics can only be held at infrequent intervals.

During the period under review five children were transferred to the adult Cardiac Clinic at Harrogate Hospital, while three others left the area and 12 were returned to the care of their general practitioners. Two children were referred to the cardiac unit in Leeds for further investigation."

THE SCHOOL DENTAL SERVICE

On the 31st December the full-time dental staff in post and the authorised establishments were as follows:

	Staff	Authorised Establishment
Chief Dental Officer	1	1
County Orthodontist	1	1
Dental Specialist	1	1
Senior Clinical Dental Officers ...	2	5
Area and Senior Dental Officers ...	18	18
Dental Officers	31	43
Dental Auxiliaries	4	10

Additionally, there were four part-time staff contributing the equivalent of 1·9 full-time dental officers.

Over the year, the staffing position has held its own, a total of 24,998 sessions having been worked compared with 24,034 sessions in 1970. What is not discernible from the table is that, in the course of the year, 10 dental officers, mostly newly qualified, were appointed and five left the service. Newly appointed dental officers take some time to settle in and those without previous experience of a children's service require instruction in its objectives and some time elapses before, by a combination of instruction and personal experience, they reach their potential.

The West Riding Dental Service has been developed over a number of years into one with a considerable reputation. It has developed a fine orthodontic service, specialities in anæsthetics and advanced conservation and a staffing structure all of which, in addition to offering a comprehensive treatment service to patients, have served to attract staff and even in lean periods the service has been well staffed compared with many.

As in the past, remuneration in other branches of dentistry continues to be higher than in the local authority service and indeed the gap has widened. The scheduled disappearance of the West Riding in 1974 and, since the first Green Paper on the National Health Service in 1968, the continuing uncertainty of the future of the School Dental Service are not conducive to increased staff recruitment and one cannot help but be apprehensive with regard to future staffing, particularly when there is also to be an increase in the school population caused by the raising of the school leaving age.

Dental Auxiliaries:

The contribution made by our dental auxiliaries is considerable in proportion to their numbers. In 2,319 treatment sessions (equivalent to $5\frac{1}{3}$ full-time auxiliaries) they inserted a very commendable 18,867 fillings. If more of this class of worker were available, they could undertake a considerable proportion of the simple fillings, thereby allowing dental officers to devote more of their time to the advanced aspects of dentistry. Repeated requests are being made for a school for auxiliaries to be established in the north of the country in an effort both to increase the numbers available and to overcome the tendency of girls trained in the south to return there as soon as vacancies arise.

Courses:

The two members of staff authorised to attend the course in dental public health at Leeds University in 1970 were both successful in gaining the Diploma of the Royal College. Three members of staff are presently attending this course.

Clinics:

New clinics to come into operation this year were at Wetherby Health Centre (two-surgery) and at Castleford Health Centre (four-surgery). Both were to replace clinics in old adapted premises.

A party of students from Leeds Dental School visited the new Castleford clinic as part of a series of lectures given by the Chief Dental Officer.

Equipment:

The first instalment of the three-year programme to renew dental equipment in 34 surgeries has been completed. This equipment is in line with that being used for training of students in dental schools. Some apprehension was felt by older members of our staff with regard to their ability to adapt to its use but it is pleasing to report that, without exception, the new equipment is being used with great enthusiasm and is most acceptable to patients and staff alike.

Inspection and Treatment:

For a seven week period at the beginning of the year, the strike by Post Office workers created difficulties with the appointment system. With the co-operation of the public, however, inconvenience to patients and loss of professional time were reduced to a minimum.

The statistical details of inspection and treatment carried out throughout the year are given in Table 72 of the Appendix to the Annual Report. First inspections at school are a little higher than in 1970 and there is an increase in the number of fillings in permanent teeth. Noticeably, however, the fillings in the deciduous teeth are down by about 5 per cent., indicating a continuing inadequacy of staff and unfortunately a need to neglect the deciduous dentition in favour of caring for the second teeth.

Once again, and I make no excuse for repeating this statement in successive Annual Reports, the fluoridation of drinking water could reduce dental decay by at least 50 per cent. and it is frustrating that although this Authority declared itself in favour of fluoridating the drinking water supply in 1962, because of the failure of some other local health and water authorities in Yorkshire to adopt the same principle, the vast majority of the West Riding population is being denied the benefits to be had, although some small progress has been made.

Mr. Allen, Senior Clinical Dental Officer, has, since 1966, been providing a special service for those patients who for physical or emotional reasons find dental treatment in the conventional manner utterly unacceptable. Previous Annual Reports have described the treatment of these patients under sedation and general anæsthesia. Since January, 1971, a comparatively new method of 'relative anæsthesia' has been introduced which quite a number of these patients find acceptable. Nitrous oxide and oxygen is employed to produce a very light plane of general anæsthesia in which the patient remains conscious but relaxed and unworried about the dental work being performed. In contrast to other techniques, this method has additional advantages in that the patient does not require to be prepared and escorted as for a general anæsthetic.

Miss Neden, Dental Specialist, has completed a survey on the dental health of mongols in day special schools and training centres and writes on her findings elsewhere in this Annual Report.

Health Education:

Major campaigns were held at Dinnington, Maltby and Wickersley by Mr. Metcalfe, Area Dental Officer in charge of dental health education, in the course of which, talks on the care of the teeth were given to approximately 12,000 children. Additionally, by special invitation, visits to individual schools were made, including one to a school for educationally subnormal children. As part of a comprehensive health education campaign in Ilkley, talks on dental health were given at three schools in the town and were so well received that similar visits are likely to become an annual event.

The regular requests to address young wives' groups, mothers' clubs and parent/teacher associations continued to be met during the year.

As a representative of local authority dental services, Mr. Metcalfe was invited by the Oral Hygiene Service to address student dental hygienists at a one-day course in London, and also attended a conference on dental health organised by the Health Education Council convened to assess and evaluate the present methods of education and deliberate upon the future.

Work of the Laboratory:

There is still a national shortage of trained dental technicians. The practice of training our own continues to pay dividends and throughout the year the total staff of the laboratory was at the approved establishment of 12.

Following an inspection by officers from the Department, the laboratory has been declared an 'Approved Establishment for the Training of Dental Technicians'.

Orthodontics:

Report of Mr. Thompson, County Orthodontist:

I am pleased to be able to report another successful year in the history of the County Orthodontic Service. One thousand three hundred and fifty-six new cases were commenced, an increase of 81 over the previous year, and 1,109 cases were completed, an increase of 57 compared with 1970. These figures represent a great deal of specialised treatment because the average case takes 18 months to complete and may involve the patient in 20 visits to a clinic.

Young dental officers are anxious to increase their knowledge and experience of orthodontics and welcome the specialist advice and supervision which is available for their patients. When, in addition, this service has the facilities of a large laboratory with skilled technicians producing appliances of the highest standard, we have a valuable aid to recruitment to the County Dental Service.

Unfortunately with the integration of the health services in 1974, accompanied by the disintegration of the West Riding County Council, many parts of the present West Riding area may have a less satisfactory orthodontic service in future. This will apply especially to some of the country areas, where in future patients may have to travel long distances for specialist orthodontic treatment instead of having treatment available locally. Parents are naturally anxious that their children should have the minimum time away from school, but also desire that their children should not suffer from the handicap of irregular and unsightly teeth. Co-operative headteachers will have to be even more tolerant in the future in allowing children to attendfor orthodontic treatment at hospitals.

This orthodontic service pioneered by Mr. B. R. Townend and further developed by Miss R. Sclare will be looked at as a model of an ideal service which was years ahead of its time.

Demonstrations were given for the sixth successive year at the annual meeting of the Sheffield and District Orthodontic Study Circle and to students from Leeds Dental Hospital.

Finally, I wish to express my thanks to the Committee for being granted leave to study for the Diploma in Dental Public Health of the Royal College of Surgeons during part of 1970 and 1971.

APPENDIX A

Table		Page
1	Summary of Principal Vital Statistics, 1890-1971	151
2	Causes of Stillbirth	152
3	Perinatal Mortality, 1961-71	152
4	Causes of Infant Mortality	153
5	Infant Mortality, 1901-71	154
6	Infant Mortality, 1967-71	154
7	Neonatal Mortality, 1965-71	155
8	Mortality by Age Groups, 1967-71	155
9	Principal Causes of Death	156
10	Percentage Contribution of the Five Principal Cause Groups of Death to All Causes, 1967-71	158
11	Cancer Mortality, 1966-71	158
12	Mortality from Respiratory Diseases, 1966-71	159
13	Mortality from Violent Causes, 1965-71	159
14	Mortality from Home Accidents	160
15	Suicides	160
16	Child Mortality, 1911-71	161
17	Notification of Infectious Disease, 1966-71	162
18	Notification of Infectious Disease, 1971	163
19	Measles—Incidence and Mortality, 1958-71	164
20	Vaccination and Immunisation	164
21	Tuberculosis—Mortality	165
22	Tuberculosis—Notifications	165
23	Tuberculosis—Number of Cases on Register	166
24	B.C.G. Vaccination	167
25	Tuberculosis—Mass Radiography Surveys	169
26	Venereal and Sexually Transmissible Diseases—New Cases, 1938-71	171
27	Syphilis—Type and Stage of Disease, 1950-71	171
28	Venereal Diseases etc.—Distribution of New Cases by Treatment Centres	172
29	Venereal Diseases etc.—New Cases—Sex Distribution	172
30	Gonorrhœa—New Cases—Age Distribution	173
31	Venereal Diseases etc.—Contact Tracing	173
32	Antenatal Patients with Positive Serological Tests for Syphilis	173
33	Venereal Diseases etc.—Defaulters	174
34	Gonorrhœa—New Cases—Males/Females Numbers and Ratios, 1961-71	174
35	Divisional Administration	175
36	Dental Services for Expectant and Nursing Mothers and Children under 5 years	179
37	Antenatal Relaxation Classes	180
38	Ortolani Testing for Congenital Dislocation of Hip, 1965-71	180
39	Premature Babies	181
40	Distribution of Welfare Foods	182
41	Midwifery—Hospital and Domiciliary Confinements	183
42	Midwifery—Analgesia	184
43	Health Visiting	185
44	Home Nursing—Total Cases Visited	186
45	Home Nursing—Completed Cases	187
46	Ambulance Service	189
47	Ambulance Service—Accidents Attended	189
48	Health Education—Summary of Activities	189
49	Provision of Nursing Equipment in the Home	190
50	Chiropody Treatment	191
51	Milk (Special Designation) Regulations, 1963 and Milk (Special Designation) (Amendment) Regulations, 1965—Dealers Licensed	192
52	Milk (Special Designation) Regulations, 1963 and Milk (Special Designation) (Amendment) Regulations, 1965—Details of Samples obtained from Dealers	192

Table		Page
53	Milk (Special Designation) Regulations, 1963 as amended—Licensed Establishments for Pasteurising and Sterilising Milk	192
54	Milk (Special Designation) Regulations, 1963 as amended—Details of Samples obtained from Licensed Processing Plants	193
55	County Premises with Private Supplies of Water	193
56	Applications for Grants under the Rural Water Supplies and Sewerage Acts, 1944-61	194
57	School Swimming Pools	195
58	Atmospheric Pollution	200
59	Certification and Treatment of Blind and Partially Sighted Persons—New Registrations	207
60	Registration of Nursing Homes	208
61	Medical Inspection of School Children	209
62	Care of the Handicapped Pupil	214
63	Audiology Clinics	215
64	The Work of the Psychologists	217
65	School Ophthalmic Service, 1956-71	218
66	Medical Treatment at Clinics	219
67	Consultant Services	220
68	Cleanliness, 1952-71	223
69	Nutrition, 1959-71	224
70	Protection of School Children Against Tuberculosis	224
71	Speech Therapy	225
72	Dental Inspections and Treatment	226

Table 1 Summary of Principal Vital Statistics, 1890—1971

Year	Live Birth Rate	Stillbirths per 1,000 total births	Death Rates							
			All Causes	Infective and Parasitic Diseases	Tuberculosis, Respiratory	Tuberculosis, Other Forms	*Respiratory Diseases	Cancer	Maternal Mortality per 1,000 total births	Infant Mortality
1890–1909	28·9	†	16·7	1·89	1·19	0·52‡	3·20	0·77‡	†	147
1910–1919	22·5	†	14·5	1·26	0·84	0·41	2·58	0·98	†	112
1920–1929	20·2	†	12·4	0·56	0·68	0·25	2·08	1·20	†	82
1930–1939	15·5	46	12·1	0·30	0·48	0·13	1·24	1·46	4·70	62
1940–1949	18·1	31	12·2	0·16	0·39	0·09	1·43	1·73	1·95	47
1950–1954	15·7	25	11·9	0·09	0·19	0·03	1·23	1·89	0·82	31
1955–1959	16·3	23	11·7	0·06	0·09	0·01	1·23	1·92	0·49	26
1960	16·9	22	11·5	0·06	0·06	0·01	1·15	1·98	0·73	22
1961	17·2	20	12·1	0·05	0·06	0·00	1·44	1·98	0·27	25
1962	17·8	18	12·0	0·04	0·05	0·01	1·47	2·00	0·20	23
1963	18·2	19	12·0	0·04	0·06	0·01	1·52	1·94	0·45	23
1964	18·5	18	11·5	0 04	0·05	0 00	1·35	2·02	0·40	22
1965	18·2	16	11·6	0·04	0·04	0·00	1·28	2·07	0·16	21
1966	18·0	14	12·1	0·03	0·05	0·00	1·62	2·00	0·25	20
1967	18·0	15	11·2	0·03	0·03	0·00	1·29	2·08	0·22	19
1968	17·6	14	11·6	0·04	0·03	0·01	1·60	2·14	0·09	18
1969	16·9	14	11·6	0·05	0·03	0·01	1·60	2·10	0·20	19
1970	17·3	14	11·7	0·04	0·02	0·01	1·53	2·14	0·29	20
1971	17·0	12	11·4	0·04	0·02	0·01	1·41	2·16	0·10	18

* Combined death rate from bronchitis, pneumonia and other respiratory diseases excluding tuberculosis and influenza.

† Figures not available.

‡ This rate is for the 10 years 1900-1909.

Table 2 Causes of Stillbirth

Cause and I.C.D. number	Number of stillbirths	Rate per 1,000 total births
Congenital anomalies (740-759)	86	2·77
Chronic and acute disease in mother (760, 761)	16	0 51
Maternal toxæmia and infection (762, 763)	30	0·97
Difficult labour (764-768)	12	0 39
Other complications of pregnancy and childbirth (769) ...	41	1·32
Conditions of placenta (770)	69	2·22
Conditions of umbilical cord (771)	38	1·22
Birth injury (772)	5	0·16
Hæmolytic disease of newborn (774, 775)	13	0·42
Anoxic and hypoxic conditions NEC (776)	21	0·68
Immaturity unqualified (777)	10	0·32
Other conditions of fœtus or newborn (778)	—	—
Fœtal death of unknown cause (779)...	41	1·32
All causes (740-779)	382	12·30

Table 3 Perinatal Mortality, 1961-71

	1961	1962	1963	1964	1965	1966	1967	1968	1969	1970	1971
Perinatal mortality (per 1,000 total births)	34·2	31·5	31·1	30·0	27·3	25·1	26·1	25·0	23·7	24·4	21·7
Infant deaths at 1 week and over (per 1,000 total births)	10·1	9·9	10·1	9·5	9·0	8·8	8·1	7·5	8·5	8·7	8·8

Ætiological Group	Cause of Death (and International Classification number)	Age at Death						
		Under 1 day	1 day and under 1 week	1 week and under 1 month	1 month and under 3 months	3 months and under 6 months	6 months and under 1 year	Total under 1 year
ALL CAUSES	All causes	163	129	46	85	87	56	566
Prenatal and Natal Group (including congenital malformations)	Congenital malformations (740-759)	23	29	24	18	12	7	113
	Total causes mainly of prenatal and natal origin other than congenital malformations (760-778)	134	92	7	3	1	—	237
	Chronic and acute disease and infection in mother (760-763) ...	3	1	—	—	—	—	4
	Difficult labour (764-768)	2	1	—	—	—	—	3
	Other complications of pregnancy and childbirth (769-771)	6	5	—	—	—	—	11
	Birth injury (772)	11	16	1	1	—	—	29
	Hæmolytic disease of newborn (774-775)	3	4	—	—	—	—	7
	Anoxic and hypoxic conditions NEC (776)	49	45	3	2	1	—	100
	Immaturity, unqualified (777)	59	19	2	—	—	—	80
	Other conditions of fœtus or newborn (778)	1	1	1	—	—	—	3
Postnatal Group	Total causes mainly of postnatal origin	2	6	10	50	63	35	166
	Enteritis and other diarrhœal diseases (008, 009)	—	—	1	4	—	4	9
	Whooping cough (033)	—	—	—	—	1	—	1
	Meningococcal infection (036)	—	—	—	1	—	2	3
	Other infective and parasitic diseases (remainder 000-136)	—	1	1	3	—	1	6
	Meningitis (320)	—	—	—	—	1	1	2
	Pneumonia and bronchitis (480-486, 490-492)	1	3	5	28	29	13	79
	Other diseases of the respiratory system (remainder 460-519) ...	—	1	1	10	23	12	47
	Accidental mechanical suffocation from vomit, food, foreign body, or in cot (E911-E913)	—	—	2	4	8	—	14
	Other violent causes (remainder E800-E999)	1	1	—	—	1	2	5
Unclassified	Other remaining causes	4	2	5	14	11	14	50

Table 5 Infant Mortality, 1901-71—Rates per 1,000 live births

Period	Average Infant Mortality Rate		Year	Infant Mortality Rate	
	England and Wales	Administrative County		England and Wales	Administrative County
1901-1910	128	135	1966	19	20
1911-1920	100	109	1967	18	19
1921-1930	72	80	1968	18	18
1931-1940	59	61	1969	18	19
1941-1945	50	50	1970	18	20
1946-1950	36	40	1971	18	18
1951-1955	27	29			
1956-1960	23	25			
1961-1965	21	23			

Table 6 Infant Mortality, 1967-71

	Number of Deaths					Deaths per 1,000 Live Births				
	1967	1968	1969	1970	1971	1967	1968	1969	1970	1971
Male Infants—										
Under 4 weeks	237	233	210	228	195	14·5	14·5	13·4	14·4	12·4
4 weeks—3 months ...	44	41	42	53	55	2·7	2·5	2·7	3·3	3·5
3—6 months	42	41	48	44	45	2·6	2·5	3·1	2·8	2·9
6—12 months	23	31	23	21	34	1·4	1·9	1·5	1·3	2·2
Total under 1 year ...	346	346	323	346	329	21·2	21·5	20·7	21·8	21·0
Female Infants—										
Under 4 weeks	176	146	161	181	143	11·6	9·6	11·0	12·0	9·5
4 weeks—3 months ...	40	35	38	31	30	2·6	2·3	2·6	2·0	2·0
3—6 months	24	34	33	35	42	1·6	2·2	2·3	2·3	2·8
6—12 months	21	16	18	21	22	1·4	1·1	1·2	1·4	1·5
Total under 1 year ...	261	231	250	268	237	17·2	15·3	17·1	17·7	15·8
All Infants—										
Under 4 weeks	413	379	371	409	338	13·1	12·1	12·3	13·2	11·0
4 weeks—3 months ...	84	76	80	84	85	2·7	2·4	2·6	2·7	2·8
3—6 months	66	75	81	79	87	2·1	2·4	2·7	2·5	2·8
6—12 months	44	47	41	42	56	1·4	1·5	1·4	1·4	1·8
Total under 1 year ...	607	577	573	614	566	19·2	18·5	18·9	19·8	18·4

Table 7 Neonatal Mortality, 1965-71

	Number of Deaths							Deaths per 1,000 Live Births						
	1965	1966	1967	1968	1969	1970	1971	1965	1966	1967	1968	1969	1970	1971
Under 1 day ...	200	191	188	199	172	197	163	6·4	6·1	6·0	6·4	5·7	6·3	5·3
1—6 days	163	152	161	139	140	142	129	5·2	4·8	5·1	4·5	4·6	4·6	4·2
1—4 weeks ...	75	54	64	41	59	70	46	2·4	1·7	2·0	1·3	1·9	2·3	1·5
Total under 4 weeks	438	397	413	379	371	409	338	13·9	12·6	13·1	12·1	12·3	13·2	11·0

Table 8 Mortality by Age Groups, 1967—71

Age Group	1967	1968	1969	1970	1971
Under 1 year	607	577	573	614	566
1 and under 5	90	93	102	88	65
5—14	91	116	106	93	97
15—24	217	168	201	170	186
25—34	205	172	182	195	177
35—44	442	487	493	449	441
45—54	1,271	1,309	1,302	1,280	1,312
55—64	3,314	3,308	3,409	3,379	3,230
65—74	5,468	5,834	6,096	6,118	5,859
75 and over	7,968	8,559	8,334	8,631	8,652
Totals	19,673	20,623	20,798	21,017	20,585

Table 9 Principal Causes of Death, 1971

	Cause of death	Age at death											
		Under 4 weeks	4 weeks & under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 55	55 and under 65	65 and under 75	75 and over	Total
B. 1	Cholera	—	—	—	—	—	—	—	—	—	—	—	—
B. 2	Typhoid fever	—	—	—	—	—	—	—	—	—	—	—	—
B. 3	Bacillary dysentery and amœbiasis	—	—	—	—	—	—	—	—	—	—	—	—
B. 4	Enteritis and other diarrhœal diseases	1	8	1	—	—	—	—	2	1	5	3	21
B. 5	Tuberculosis of respiratory system	—	—	—	—	—	2	3	5	8	6	8	32
B. 6(1)	Late effects of respiratory tuberculosis	—	—	—	—	—	—	—	—	1	1	3	5
B. 6(2)	Other tuberculosis	—	—	2	—	1	—	1	—	—	—	1	5
B. 7	Plague	—	—	—	—	—	—	—	—	—	—	—	—
B. 8	Diphtheria	—	—	—	—	—	—	—	—	—	—	—	—
B. 9	Whooping cough	—	1	1	—	—	—	—	—	—	—	—	2
B. 10	Streptococcal sore throat and scarlet fever	—	—	—	—	—	—	—	—	—	—	—	—
B. 11	Meningococcal infection	—	3	—	1	—	—	—	—	—	—	—	4
B. 12	Acute poliomyelitis	—	—	—	—	—	—	—	—	—	—	—	—
B. 13	Smallpox	—	—	—	—	—	—	—	—	—	—	—	—
B. 14	Measles	—	—	2	—	1	—	—	—	—	—	—	3
B. 15	Typhus and other rickettsioses	—	—	—	—	—	—	—	—	—	—	—	—
B. 16	Malaria	—	—	—	—	—	1	—	—	—	—	—	1
B. 17	Syphilis and its sequelæ	—	—	—	—	—	—	—	—	2	1	1	4
B. 18	All other infective and parasitic diseases	2	4	2	1	—	—	1	4	9	6	1	30
	Total—Infective and Parasitic Diseases excluding Tuberculosis	3	16	6	2	1	1	1	6	12	12	5	65
B. 19(1)	Malignant neoplasm, buccal cavity, etc.	—	—	—	—	1	—	4	2	16	17	11	51
B. 19(2)	Malignant neoplasm, oesophagus	—	—	—	—	—	—	—	6	31	26	17	80
B. 19(3)	Malignant neoplasm, stomach	—	—	—	—	1	2	10	32	98	169	158	470
B. 19(4)	Malignant neoplasm, intestine	—	—	—	—	—	1	8	37	132	185	180	543
B. 19(5)	Malignant neoplasm, larynx	—	—	—	—	—	—	—	—	6	8	4	18
B. 19(6)	Malignant neoplasm, lung, bronchus	—	—	—	—	—	4	19	108	287	356	166	940
B. 19(7)	Malignant neoplasm, breast	—	—	—	—	—	6	25	62	94	96	68	351
B. 19(8)	Malignant neoplasm, uterus	—	—	—	—	—	1	9	27	47	37	32	153
B. 19(9)	Malignant neoplasm, prostate	—	—	—	—	—	—	—	1	17	52	82	152
B. 19(10)	Leukæmia	—	—	3	11	2	4	3	16	17	27	21	104
B. 19(11)	Other malignant neoplasms	—	1	1	5	15	17	38	121	228	317	292	1,035
	Total—Malignant Neoplasms	—	1	4	16	19	35	116	412	973	1,290	1,031	3,897
B. 20	Benign neoplasms and neoplasms of unspecified nature	1	2	—	2	2	3	2	9	8	13	13	55
B. 21	Diabetes mellitus	—	—	—	1	3	3	2	6	28	56	82	181
B. 22	Avitaminoses and other nutritional deficiency	—	—	—	—	—	—	—	—	2	—	4	6
B. 46(1)	Other endocrine, nutritional and metabolic disorders	2	5	3	5	3	—	1	4	9	14	15	61
B. 23	Anæmias	—	—	—	1	1	—	—	3	6	12	32	55
B. 46(2)	Other diseases of blood and blood forming organs	—	—	1	—	—	1	—	—	1	1	2	6
B. 46(3)	Mental disorders	—	—	—	—	—	1	2	3	3	13	25	47
B. 24	Meningitis	—	2	1	1	1	—	—	1	2	2	1	11
B. 46(4)	Multiple sclerosis	—	—	—	—	—	1	3	8	12	7	—	31
B. 46(5)	Other diseases of nervous system and sense organs	—	9	2	6	5	5	13	20	35	56	82	233

Table 9 Principal Causes of Death (*continued*)

Cause of death	Age at death											
	Under 4 weeks	4 weeks & under 1 year	1 and under 5	5 and under 15	15 and under 25	25 and under 35	35 and under 45	45 and under 55	55 and under 65	65 and under 75	75 and over	Total
B. 25 Active rheumatic fever	—	—	—	—	1	—	—	—	—	—	—	1
B. 26 Chronic rheumatic heart disease ...	—	—	—	—	1	6	19	41	62	66	47	242
B. 27 Hypertensive disease	—	1	—	1	—	2	6	17	48	104	144	323
B. 28 Ischæmic heart disease	—	—	—	—	—	10	92	405	1,007	1,830	2,174	5,518
B. 29 Other forms of heart disease	—	3	—	3	5	2	9	19	62	200	639	942
B. 30 Cerebrovascular disease	—	—	—	2	4	7	35	79	305	846	1,867	3,145
B. 46(6) Other diseases of the circulatory system	—	—	—	—	—	2	9	25	80	223	586	925
Total—Diseases of the Circulatory System	—	4	—	6	11	29	170	586	1,564	3,269	5,457	11,096
B. 31 Influenza...	—	—	—	1	—	—	1	5	4	4	9	24
B. 32 Pneumonia	9	69	10	4	4	1	11	29	99	220	649	1,105
B. 33(1) Bronchitis, emphysema...	—	1	1	—	2	—	6	51	183	463	453	1,160
B. 33(2) Asthma	—	—	—	1	2	2	5	9	10	10	4	43
B. 46(7) Other diseases of the respiratory system	2	45	8	2	5	1	3	13	27	47	81	234
Total—Diseases of the Respiratory System	11	115	19	8	13	4	26	107	323	744	1,196	2,566
B. 34 Peptic ulcer	—	—	—	—	—	—	2	8	24	43	47	124
B. 35 Appendicitis	—	—	1	1	1	—	1	2	2	6	2	16
B. 36 Intestinal obstruction, hernia	5	5	—	—	—	—	1	2	6	22	44	85
B. 37 Cirrhosis of liver	—	1	—	—	—	—	1	14	14	11	11	52
B. 46(8) Other diseases of digestive system ...	1	—	1	—	—	3	4	10	18	63	86	186
B. 38 Nephritis and nephrosis	—	1	—	1	3	5	4	10	19	19	25	87
B. 39 Hyperplasia of prostate	—	—	—	—	—	—	—	1	3	8	32	44
B. 46(9) Other diseases of genito-urinary system	1	2	—	3	1	2	3	10	19	32	64	137
B. 40 Abortion...	—	—	—	—	—	—	1	—	—	—	—	1
B. 41 Other complications of pregnancy, childbirth and puerperium	—	—	—	—	1	1	—	—	—	—	—	2
B. 46(10) Diseases of skin and subcutaneous tissue	—	—	—	—	—	—	1	—	2	3	7	13
B. 46(11) Diseases of the musculoskeletal system	—	—	—	—	1	1	2	5	7	26	61	103
B. 42 Congenital anomalies	76	37	7	10	7	3	5	4	10	6	1	166
B. 43 Birth injury, difficult labour, and other anoxic and hypoxic conditions ...	128	4	—	—	—	—	—	—	—	—	—	132
B. 44 Other causes of perinatal mortality ...	105	—	—	—	—	—	—	—	—	—	—	105
B. 45 Symptoms and ill-defined conditions...	1	9	1	—	—	1	—	1	2	12	110	137
BE. 47 Motor vehicle accidents	—	1	8	17	70	33	22	23	38	33	33	278
BE. 48 All other accidents	4	13	7	17	26	20	20	13	29	45	151	345
BE. 49 Suicide and self-inflicted injuries ...	—	—	—	—	12	19	24	27	41	23	20	166
BE. 50 All other external causes	—	1	2	—	4	4	10	12	9	11	1	54
Total—Accidents, Poisonings, Violence (External Causes)	4	15	17	34	112	76	76	75	117	112	205	843
Total—All causes	338	228	65	97	186	177	441	1,312	3,230	5,859	8,652	20,585

Table 10 Percentage Contribution of the Five Principal Cause Groups of Death to All Causes, 1967—71

Cause Group	1967	1968	1969	1970	1971
Circulatory diseases except cerebrovascular disease	37·9	37·3	37·7	37·9	38·6
Malignant neoplasms	18·6	18·4	18·0	18·3	18·9
Cerebrovascular disease	15·4	15·2	14·6	14·9	15·3
Diseases of respiratory system ...	11·6	14·3	14·6	14·4	12·5
Accidents, suicide and violence ...	4·9	4·5	4·6	4·1	4·1
Total	88·4	89·7	89·5	89·7	89·4

Table 11 Cancer Mortality, 1966—71

Year		Stomach	Lung, Bronchus	Breast	Uterus	Other Malignant and Lymphatic Neoplasms	Leukæmia, Aleukæmia	Total All Sites
1966	M.	236	667	3	—	896	46	1,848
	F.	216	116	320	163	795	45	1,655
	T.	452	783	323	163	1,691	91	3,503
1967	M.	283	707	8	—	925	49	1,972
	F.	186	109	313	158	868	49	1,683
	T.	469	816	321	158	1,793	98	3,655
1968	M.	254	713	1	—	969	65	2,002
	F.	212	141	348	151	889	58	1,799
	T.	466	854	349	151	1,858	123	3,801
1969	M.	272	742	3	—	922	74	2,013
	F.	185	129	332	143	906	45	1,740
	T.	457	871	335	143	1,828	119	3,753
1970	M.	248	771	1	—	1,014	62	2,096
	F.	210	127	347	166	847	55	1,752
	T.	458	898	348	166	1,861	117	3,848
1971	M.	286	793	3	—	994	62	2,138
	F.	184	147	348	153	885	42	1,759
	T.	470	940	351	153	1,879	104	3,897

Table 12 Mortality from Respiratory Diseases, 1966—71

Year	Influenza	Pneumonia	Bronchitis	Other diseases of the Respiratory System	Total
1966	174	1,135	1,488	216	3,013
1967	10	930	1,156	185	2,281
1968	110	1,259	1,267	305	2,941
1969	162	1,280	1,323	262	3,027
1970	285	1,196	1,257	287	3,025
1971	24	1,105	1,160	277	2,566

Table 13 Mortality from Violent Causes, 1965—71

Year	Motor Vehicle Accidents	Accidents in the Home	All other Accidents	Suicide	All other external causes	Total Accidents, Poisoning, Violence
1965	301	284	168	176	8	937
1966	295	293	200	186	13	987
1967	315	266	170	189	15	955
1968	277	238	151	177	82	925
1969	272	260	173	182	77	964
1970	269	222	147	156	75	869
1971	278	198	147	166	54	843

Table 14 Mortality from Home Accidents

Cause of Death		Age at Death—Years							
		Under 1	1-4	5–44	45–54	55–64	65–74	75 and over	All ages
Accidental poisoning by solid and liquid substances ...	M.	—	—	2	1	—	—	—	3
	F.	—	—	3	1	3	—	1	8
Accidental poisoning by gases and vapours	M.	—	—	1	—	—	2	2	5
	F.	—	—	—	—	2	2	5	9
Accidental falls	M.	1	—	1	—	4	9	25	40
	F.	—	1	4	—	4	11	73	93
Accidents caused by burns and scalds	M.	—	—	1	—	1	1	4	7
	F.	—	—	—	—	—	1	4	5
Inhalation of food or vomit ...	M.	3	—	2	—	—	—	—	5
	F.	4	—	1	—	—	—	—	5
Accidental mechanical suffocation	M.	5	—	—	—	—	—	—	5
	F.	2	1	—	1	—	—	—	4
Other and unspecified accidents	M.	—	—	2	1	—	—	—	3
	F.	—	—	1	—	3	2	—	6
Total	M.	9	—	9	2	5	12	31	68
	F.	6	2	9	2	12	16	83	130

Table 15 Suicides

External Agent		Age at Death — Years								
		Under 15	15-24	25-34	35-44	45-54	55-64	65-74	75 and over	All ages
Domestic gas poisoning ...	M.	—	2	1	4	—	4	2	3	16
	F.	—	—	—	—	1	—	—	—	1
Other poisoning	M.	—	4	8	6	13	11	6	—	48
	F.	—	1	4	7	5	13	7	6	43
Hanging or strangulation ...	M.	—	1	4	2	4	4	2	1	18
	F.	—	1	—	1	1	1	—	—	4
Drowning	M.	—	—	—	1	1	3	1	4	10
	F.	—	—	—	1	—	—	3	4	8
Firearms	M.	—	—	2	—	1	1	—	—	4
	F.	—	—	—	—	—	—	—	—	—
Jumping before or lying in path of moving vehicles	M.	—	2	—	—	—	2	—	—	4
	F.	—	—	—	—	—	—	1	—	1
Jumping from high places ...	M.	—	—	—	1	—	—	—	—	1
	F.	—	—	—	—	—	—	—	—	—
Other agents	M.	—	1	—	—	1	1	—	2	5
	F.	—	—	—	1	—	1	1	—	3
Total—All Agents ...	M.	—	10	15	14	20	26	11	10	106
	F.	—	2	4	10	7	15	12	10	60

Cause of Death	Annual Averages for Quinquennia								1970	1971
	1911–15	1927–31	1935–39	1945–49	1950–54	1955-59	1960-64	1965-69		
Measles	439	107	27	10	4	2	2	1	—	2
Whooping cough	167	67	29	11	5	1	<1	<1	—	1
Diphtheria	110	47	51	5	1	—	<1	—	—	—
Other infective and parasitic diseases, excluding tuberculosis	54	45	18	7	9	7	3	3	5	2
Tuberculosis, respiratory ...	47	13	5	4	1	—	<1	—	—	—
Tuberculosis, other	201	82	37	30	11	2	<1	—	1	2
Cancer	3	5	4	4	9	9	11	12	11	4
Heart and circulatory diseases	4	3	2	1	—	1	1	<1	2	—
Influenza	6	43	10	4	2	2	<1	<1	—	—
Pneumonia	457	321	121	42	19	14	14	14	12	10
Bronchitis	150	42	10	9	6	6	6	1	2	1
Other diseases of respiratory system	49	15	6	3	2	2	1	5	6	8
Diarrhœa and other digestive diseases	248	45	38	17	4	4	5	6	6	3
Congenital debility, malformations	12	9	7	12	13	12	11	10	7	7
Accidents	82	54	50	38	27	23	27	28	20	15
Other causes	323	119	52	30	23	12	22	15	16	10
All causes	2,352	1,017	467	227	136	97	107	96	88	65
Death rate per 1,000 living in the age group	17·13	10·62	5·09	2·23	1·29	0·99	0·97	0·82	0·72	0·53

Table 17 Notification of Infectious Disease, 1966-71

Disease	Number of corrected notifications					
	1966	1967	1968	1969	1970	1971
Measles	17,567	13,528	15,291	3,392	16,351	4,869
Dysentery	630	357	691	476	287	406
Scarlet fever	1,353	1,145	794	1,053	661	740
Diphtheria	—	—	—	—	—	—
Acute meningitis:						
Meningococcus	‡	‡	8	48	22	17
Other specified organisms					11	8
Unspecified organisms ...					22	5
Acute poliomyelitis:						
Paralytic	—	—	1	—	—	—
Non-paralytic	—	—	—	—	—	—
Acute encephalitis:						
Infective	3	5	3	1	2	—
Post-infectious	—	3	1	—	1	—
Leptospirosis	‡	‡	—	—	—	—
Paratyphoid fever	1	1	1	2	—	2
Typhoid fever...	—	—	1	—	2	—
Food poisoning	68	56	204	109	145	114
Tetanus	‡	‡	—	—	—	—
Infective jaundice	‡	‡	473	756	694	589
Whooping cough	651	1,805	591	181	694	857
Anthrax	2	—	—	—	—	—
Leprosy	2	—	—	—	—	—
†Malaria	—	1	—	2	4	1
Ophthalmia neonatorum ...	3	5	2	2	7	1
Smallpox	—	—	—	—	—	—
Yellow fever	‡	‡	—	—	—	—
Tuberculosis:						
Respiratory	355	275	299	268	265	263
Other forms...	68	47	46	36	42	48

†All the cases were believed to be contracted abroad.

‡Figures not available.

Table 18 Notification of Infectious Disease, 1971

Numbers originally notified	Measles (excluding rubella)		Dysentery		Scarlet fever		Acute meningitis due to infection with: Meningococcus		Other specified organisms		Un-specified organisms	
	M	F	M	F	M	F	M	F	M	F	M	F
Total (All ages)	2,535	2,329	270	268	354	386	8	9	5	3	3	2
Final numbers after correction												
Under 1 year	156	124	11	13	2	4	1	3	1	—	—	—
1—	273	260	13	12	11	8	1	1	1	—	—	—
2—	263	236	18	16	25	25	—	—	—	1	—	—
3—	344	320	20	16	39	26	—	—	—	—	1	—
4—	382	353	15	11	34	43	—	—	—	—	—	—
5— 9 years	1,016	968	52	42	183	225	2	—	2	—	—	—
10—14 ,,	66	40	17	8	38	39	1	—	—	—	—	—
15—24 ,,	18	12	13	23	11	12	2	—	—	1	1	—
25 and over	4	7	37	47	6	4	1	5	1	1	1	2
Age unknown	12	15	6	16	4	1	—	—	—	—	—	—
Total (All ages)	2,534	2,335	202	204	353	387	8	9	5	3	3	2

Numbers originally notified	Acute encephalitis: Infective		Acute encephalitis: Post-infectious		Paratyphoid fever		Typhoid fever		Food poisoning	
	M	F	M	F	M	F	M	F	M	F
Total (All ages)	—	—	—	—	1	1	—	—	455	352
Final numbers after correction										
Under 5 years	—	—	—	—	—	—	—	—	16	15
5—14 years	—	—	—	—	—	—	—	—	12	10
15—44 ,,	—	—	—	—	1	1	—	—	20	17
45—64 ,,	—	—	—	—	—	—	—	—	3	8
65 and over	—	—	—	—	—	—	—	—	5	6
Age unknown	—	—	—	—	—	—	—	—	1	1
Total (All ages)	—	—	—	—	1	1	—	—	57	57

Numbers originally notified	Infective jaundice		Whooping cough	
	M	F	M	F
Total (All ages)	304	285	386	470
Final numbers after correction				
Under 1 year	—	1	43	61
1—	1	2	33	32
2— 4 years	20	13	154	180
5— 9 ,,	90	80	136	175
10—14 ,,	65	62	12	11
15—19 ,,	24	29	2	3
20—24 ,,	26	25	—	1
25—34 ,,	27	35	2	2
35—44 ,,	19	13	1	—
45—54 ,,	17	3	1	—
55—64 ,,	6	10	—	—
65—74 ,,	3	3	1	1
75 and over	—	2	—	—
Age unknown	5	8	3	3
Total (All ages)	303	286	388	469

Table 19 Measles—Incidence and Mortality, 1958—71

Year	Number of notifications	Number of deaths	Fatality ratio (deaths per 100 notifications)	Year	Number of notifications	Number of deaths	Fatality ratio (deaths per 100 notifications)
1958	6,183	1	0·02	1965	18,175	3	0·02
1959	24,480	6	0·02	1966	17,567	3	0·02
1960	4,636	—	—	1967	13,528	3	0·02
1961	29,225	8	0·03	1968	15,291	3	0·02
1962	11,485	3	0·03	1969	3,392	—	—
1963	19,882	5	0·03	1970	16,351	3	0·02
1964	14,385	5	0·03	1971	4,869	3	0·06

Table 20 Vaccination and Immunisation

The following table gives the number of persons under the age of 16 years who were vaccinated or immunised against diphtheria, whooping cough, tetanus and poliomyelitis during the year ended the 31st December, 1971.

	Year of Birth						
Primary Courses	1971	1970	1969	1968	1964-1967	Others under Age 16	Total
Diphtheria	459	19,425	6,110	450	1,292	524	28,260
Whooping Cough	456	19,196	6,036	409	230	77	26,404
Tetanus	459	19,423	6,111	451	1,265	926	28,635
Poliomyelitis	438	19,476	6,140	429	1,281	411	28,175
Reinforcing Doses							
Diphtheria	13	413	388	159	22,643	4,674	28,290
Whooping Cough	11	392	353	99	1,548	274	2,677
Tetanus	13	418	465	269	22,860	6,603	30,628
Poliomyelitis	11	411	383	154	21,423	3,395	25,777

Table 21 Tuberculosis—Mortality

Classification	Age at Death in Years																				Total		Grand Total
	0—		1—		5—		15—		25—		35—		45—		55—		65—		75—				
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
Respiratory ...	–	–	–	–	–	–	–	–	1	1	1	2	2	3	7	1	5	1	5	3	21	11	32
Other	–	–	–	2	–	–	–	1	–	–	–	1	–	–	1	–	–	1	3	1	4	6	10
Totals ...	–	–	–	2	–	–	–	1	1	1	1	3	2	3	8	1	5	2	8	4	25	17	42

Table 22 Tuberculosis—Notifications

	Age Periods													Total all Ages
	0–	1–	2–	5–	10–	15–	20–	25–	35–	45–	55–	65–	75–	
FORMAL NOTIFICATIONS:														
Respiratory, Males	–	–	2	5	7	13	19	25	15	23	28	28	9	174
Respiratory, Females ...	1	–	2	1	4	5	10	22	17	11	5	7	4	89
Non-respiratory, Males ...	–	1	–	1	–	6	1	3	6	3	1	1	1	24
Non-respiratory, Females ...	–	–	2	1	2	1	3	3	6	1	2	2	1	24
														311
SUPPLEMENTAL NOTIFICATIONS:														
Respiratory, Males ...	–	–	–	–	–	–	–	–	–	1	3	4	2	10
Respiratory, Females ...	–	–	–	–	–	1	–	–	–	1	–	1	2	5
Non-respiratory, Males ...	–	–	–	–	–	–	–	–	–	–	–	–	–	–
Non-respiratory, Females	–	–	–	–	–	–	–	–	–	–	–	–	–	–
														15

The sources of information of the supplemental notifications were—death returns from local Registrars (7 respiratory), death returns from Registrar General (2 respiratory) and posthumous notifications (6 respiratory).

Div. No.	Number of cases on register 1st January, 1971				Number of cases added to register				Number of cases removed from register				Number of cases remaining on register 31st December, 1971					
	Respiratory		Non-Respiratory		Respiratory		Non-Respiratory		Respiratory		Non-Respiratory		Respiratory		Non-Respiratory		Total	Per 1,000 Population
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F		
1	104	46	18	21	9	3	1	2	13	10	2	4	100	39	17	19	175	2·1
3	132	48	6	7	12	9	5	—	19	8	1	2	125	49	10	5	189	3·4
4	129	61	4	5	4	4	3	2	10	4	—	—	123	61	7	7	198	2·7
5	253	142	18	24	22	6	1	3	5	2	—	1	270	146	19	26	461	3·5
7	105	42	—	4	7	5	1	1	15	9	—	1	97	38	1	4	140	1·2
9	126	96	29	20	9	7	1	—	7	4	—	—	128	99	30	20	277	2·0
10	65	41	6	12	1	—	—	1	6	4	—	1	60	37	6	12	115	2·3
11	362	236	58	68	22	6	1	2	30	21	—	—	354	221	59	70	704	5·5
13	70	53	12	21	9	8	—	1	5	6	1	—	74	55	11	22	162	1·7
15	66	54	43	16	11	8	4	3	10	7	5	1	67	55	42	18	182	1·7
18	185	82	11	12	7	17	—	2	21	19	—	4	171	80	11	10	272	2·4
20	87	55	17	22	14	6	1	1	13	19	1	2	88	42	17	21	168	1·7
23	189	118	25	36	7	5	—	2	13	10	—	1	183	113	25	37	358	5·4
Leeds R.H.B.	1,873	1,074	247	268	134	84	18	20	167	123	10	17	1,840	1,035	255	271	3,401	2·7
22	241	117	74	52	8	8	—	3	46	28	12	15	203	97	62	40	402	4·9
25	189	119	8	16	6	4	1	1	49	34	2	1	146	89	7	16	258	3·3
26	275	148	35	44	21	8	—	1	16	6	—	1	280	150	35	44	509	4·7
27	160	105	70	50	17	9	4	1	17	7	—	—	160	107	74	51	392	3·1
29	54	34	19	5	8	—	1	—	7	3	—	—	55	31	20	5	111	2·8
31	164	65	41	35	11	4	—	—	3	1	—	—	172	68	41	35	316	2·9
Sheff. R.H.B.	1,083	588	247	202	71	33	6	6	138	79	14	17	1,016	542	239	191	1,988	3·6
West Riding	2,956	1,662	494	470	205	117	24	26	305	202	24	34	2,856	1,577	494	462	5,389	3·0

Table 24 B.C.G. Vaccination

Details of B.C.G. vaccination given to the various categories under Section 28 of the National Health Service Act are shown below:

(a) CONTACTS.—A total of 1,330 contacts were vaccinated as follows:

Age (years)			
0–4	5–15	16+	Total
891	328	111	1,330

(b) SCHOOL CHILDREN.—A total of 20,691 school children were vaccinated under the County scheme, and the following is a summary of the work carried out.

Acceptances:

Number of children offered tuberculin testing and vaccination if necessary	29,694
Number found to have been vaccinated previously	506
Number of acceptances	25,385
Percentage of acceptances	87·0

Pre-vaccination tuberculin test:

Number of children tested	23,883

Result of test:

	Heaf Test	*Mantoux Test*		
Positive	... 1,709	6		
Negative	... 20,801	86		
Not ascertained ...	... 1,277	4	Total	23,883
Percentage positive ...	... 7·6	6·5	...	7·6

Vaccination:

Number vaccinated—			
Following negative Heaf Test	20,605		
Following negative Mantoux Test	86	Total ...	20,691

Tuberculin test 12 months after vaccination:

Number tuberculin tested after 12 months			968
Result of test—			
Positive	842		
Negative	48		
Not ascertained	78	Total ...	968

(c) Students attending Universities, Teacher-Training Colleges, Technical Colleges or other Establishments for Further Education.

No students were tuberculin tested during 1971.

Table 25 Tuberculosis—Mass Radiography Surveys

A.—Leeds Units

Survey undertaken in Division No.	Number Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
1 (Skipton)...	1,110	—	—	9	9
3 (Keighley)	3,186	14	—	14	28
4 (Shipley)...	380	—	—	—	—
5 (Horsforth)	3,933	3	11	14	28
7 (Harrogate)	1,344	3	1	7	11
9 (Rothwell/Wetherby)	2,247	2	2	14	18
10 (Goole)	1,716	—	2	14	16
11 (Castleford/Pontefract)...	4,659	3	4	15	22
13 (Morley)...	2,518	1	1	3	5
15 (Spenborough)	2,655	3	4	10	17
18 (Calder Valley)	4,015	4	—	20	24
20 (Colne Valley)	4,535	—	5	21	26
23 (Hemsworth)	1,127	—	—	6	6
Totals	33,425	33	30	147	210

B.—Sheffield Units

Survey undertaken in Division No.	Number Examined	Abnormalities Discovered			
		Tuberculosis		* Other	Total
		Active	Inactive		
26 (Wath)	1,032	—	—	24	24
27 (Doncaster)	1,080	—	2	56	58
29 (Thorne)...	194	—	—	1	1
Totals	2,306	—	2	81	83

Totals for the County Area ...	35,731	33	32	228	293

*Details of the 228 " Other " abnormalities are as follows:

	Leeds Region	*Sheffield Region*
1. Abnormalities of the bony thorax and soft tissues—congenital	—	—
2. Abnormalities of the bony thorax and soft tissues—acquired	3	—
3. Tumours of the bony thorax; primary and secondary	—	—
4. Congenital malformations of the lungs	—	—
5. Bacterial and virus infections of the lungs ...	27	—
6. Other infections of the lungs	6	3
7. Bronchiectasis	15	5
8. Honeycomb lung	1	—
9. Emphysema	2	8
10. Pulmonary fibrosis—non-tuberculous	33	5
11. Pneumoconiosis—uncertified at time of attendance	—	15
11. Pneumoconiosis—already certified at time of attendance	4	19
12. Spontaneous pneumothorax	3	—
13. Benign tumours of lungs and mediastinum ...	3	1
14. Carcinoma of the lung and mediastinum ...	13	1
15. Metastases in the lung and mediastinum	1	—
16. Enlarged mediastinal and bronchial glands—non-tuberculous	2	—
17. Sarcoidosis and collagenous disease	2	—
18. Pleural thickening or calcification—non-tuberculous	5	6
19. Abnormalities of diaphragm and œsophagus—congenital and acquired	7	—
20. Congenital abnormalities of heart and vessels ...	4	3
21. Acquired abnormalities of heart and vessels ...	11	10
22. Miscellaneous	3	5
23. Pneumoconiosis with tuberculosis	1	—
24. Awaiting classification	1	—
	147	81

Table 26 Venereal and Sexually Transmissible Diseases—New Cases, 1938-71

Year	Syphilis	Gonorrhœa	Other Genital Infections	Other Conditions	Total of New Cases
1938	346	650		503	1,499
1939	403	678		593	1,674
1940	299	499		497	1,295
1941	331	552		587	1,470
1942	423	479		735	1,637
1943	487	654		1,344	2,485
1944	413	560		1,383	2,356
1945	473	767		1,419	2,659
1946	723	1,140		1,859	3,722
1947	573	729		1,511	2,813
1948	463	550		1,403	2,416
1949	435	383		1,360	2,178
1950	357	304		1,447	2,108
1951	247	171		1,212	1,630
1952	219	211		1,275	1,705
1953	214	182		1,228	1,624
1954	178	152		1,189	1,519
1955	175	135		1,168	1,478
1956	155	99		1,143	1,397
1957	152	125		1,078	1,355
1958	124	138		1,129	1,391
1959	112	405		1,352	1,869
1960	83	338		1,550	1,971
1961	85	286		1,669	2,040
1962	69	244		1,623	1,936
1963	74	272		1,734	2,080
1964	67	286		1,841	2,194
1965	57	327		2,153	2,537
1966	48	406		2,160	2,614
1967	47	510		2,255	2,812
1968	47	506		2,527	3,080
1969	30	537		2,845	3,412
1970	41	588		3,204	3,833
1971	38	647	2,044	1,759	4,448

Figures not available

Table 27 Syphilis—Type and Stage of Disease, 1950-71

Year	Syphilis			
	Acquired		Congenital	
	Early	Late	Under 1 year	Over 1 year
1950	76	221	4	56
1951	58	144	4	41
1952	19	163	1	36
1953	9	155	1	49
1954	7	144	—	27
1955	6	128	1	40
1956	9	120	—	26
1957	1	122	—	29
1958	5	99	—	20
1959	12	80	—	20
1960	—	73	—	10
1961	4	67	—	14
1962	4	55	1	9
1963	5	57	—	12
1964	8	51	1	7
1965	8	45	—	4
1966	10	34	—	4
1967	8	33	—	6
1968	7	35	—	5
1969	9	18	—	3
1970	6	23	—	12
1971	9	26	—	3

Table 28 Venereal Diseases etc.—Distribution of New Cases by Treatment Centres

Special Treatment Centre	Syphilis	Gonorrhœa	Other Genital Infections	Other Conditions	Total
Airedale General Hospital	2	47	78	55	182
Barnsley Clinic, Queen's Road	—	16	154	124	294
Bradford St. Luke's Hospital	1	64	135	150	350
Burnley General Hospital	3	3	8	11	25
Dewsbury General Hospital	2	32	154	100	288
Doncaster Royal Infirmary	6	110	336	225	677
Halifax Royal Infirmary...	3	35	33	63	134
Harrogate General Hospital	4	30	90	100	224
Huddersfield Royal Infirmary	1	48	48	73	170
Hull, Mill Street Clinic	—	4	—	31	35
Leeds General Infirmary...	3	114	359	305	781
Oldham & District General Hospital ...	—	2	2	6	10
Rotherham Moorgate General Hospital	2	38	152	98	290
Sheffield Royal Infirmary	—	26	66	119	211
Wakefield Clayton Hospital	8	69	353	261	691
York County Hospital	3	9	36	38	86
	38	647	2,004	1,759	4,448

Table 29 Venereal Diseases etc.—New Cases—Sex Distribution

	Males	Females	Total
Syphilis	18	20	38
Gonorrhœa	406	241	647
Chancroid	1	—	1
Lymphogranuloma Venereum	—	—	—
Granuloma Inguinale	—	—	—
Non-specific genital infection	826	153	979
Non-specific genital infection with arthritis	23	—	23
Trichomoniasis	35	225	260
Candidiasis	70	276	346
Scabies	50	12	62
Pubic lice	29	8	37
Herpes simplex	36	1	37
Warts	162	95	257
Molluscum Contagiosum	1	1	2
Other treponemal diseases	1	—	1
Other conditions requiring treatment...	352	68	420
Other conditions not requiring treatment	743	595	1,338
	2,753	1,695	4,448

Table 30 Gonorrhœa—New Cases—Age Distribution

Sex	Under 20		20 to 24		25 and over	
Males	48	12%	138	34%	220	54%
Females	70	29%	83	34%	88	37%

Table 31 Venereal Diseases etc.—Contact Tracing

Total number of contacts reported ...	66				
Located and examined		45			
Not infected			11		
Infected			34		
Already under treatment ...				—	
Brought under treatment ...				34	
Syphilis					3
Gonorrhœa					20
Other conditions					11
Located		7			
Not examined			7		
Transferred to other authority ...			—		
Not located		14			
Insufficient information			8		
Unable to locate			6		

Table 32 Antenatal Patients with Positive Serological Tests for Syphilis

Total number reported	Transferred to other local authorities	West Riding patients with positive tests	Not referred to Special Clinics	Referred to Special Clinics	Found to have Syphilis		Found not to have Syphilis
					New patients	Old patients	
18	8	10	8	2	—	2	—

Table 33 Venereal Diseases etc.—Defaulters

Total number of defaulters	Returned to clinic after visiting	Failed to return	Removed, unable to locate	Trans-ferred	Number of ineffective visits	Number of re-visits
45	30	5	9	1	95	64

Table 34 Gonorrhœa—New Cases—Males/Females Numbers and Ratios

Year	Gonorrhœa		Ratio	
	Males	Females	Males	Females
1961	204	82	2·5	1
1962	185	59	3·1	1
1963	187	85	2·2	1
1964	211	75	2·8	1
1965	224	103	2·2	1
1966	265	141	1·9	1
1967	341	169	2·0	1
1968	343	163	2·1	1
1969	347	190	1·8	1
1970	376	212	1 8	1
1971	406	241	1·7	1

Table 35 Divisional Administration

Div. No.	County Districts	Population (Estimated Mid. 1971)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
1	Barnoldswick U.	9,960	2,764	Dr. M. Hunter	9, High Street, Skipton Tel. Skipton 2438/9
	Earby U.	4,820	3,519	Mr. K. A. Knowles	
	Silsden U.	5,560	7,101	Miss F. Stevenson	
	Skipton U.	12,590	4,211		
	Bowland R.	5,100	83,327		
	Sedbergh R.	3 710	52,674		
	Settle R.	13,720	152,087		
	Skipton R.	26,050	146,071		
		81,510	451,754		
3	Keighley B.	55 720	23,611	Dr. V. P. McDonagh Mr. A. S. Sanderson (D.N.O. Vacant)	3, Bow Street, Keighley Tel. Keighley 2244/5
4	Baildon U.	14,660	2,831	Dr. J. Battersby	P.O. Box 24, Town Hall, Shipley Tel. Shipley 51363
	Bingley U.	23,530	11,418	Mr. F. G. Falkingham	
	Denholme U.	2,620	2,536		
	Shipley U.	28,570	2,184	Miss H. J. Watts	
		72,389	18,969		
5	Pudsey B.	38,240	5,323	Dr. A. Telford Burn	The Green, Horsforth Tel. Horsforth 5821
	Aireborough U.	29,600	6,856	Mr. A. Hartley	
	Horsforth U.	19 640	2,706	Miss D. Topley	
	Ilkley U.	21,990	8,610		
	Otley U.	13,150	2,934		
	Wharfedale R.	7,300	39,378		
		129,920	65,807		
7	Harrogate B.	63,470	8,320	Dr. N. V. Hepple	Municipal Offices, Harrogate Tel. Harrogate 68954
	Ripon City	11,800	1,812	Mr. G. W. N. Graham	
	Knaresborough U.	11,700	2,494	Miss M. L. Griffin	
	Nidderdale R.	17,730	75,009		
	Ripon and Pateley Bridge R.	13,580	124,861		
		118 280	212,496		
9	Garforth U.	25,340	4,020	Dr. E. M. Hargreaves	12 Crossley St., Wetherby Tel. Wetherby 2738 AND Oulton Lane, Rothwell LS26 0ED Tel. Rothwell 2326/7
	Rothwell U.	28,260	10,698	Mr. F. H. Atack	
	Stanley U.	20,980	4,866	Miss M. P. Bramley	
	Tadcaster R.	34,860	72,987		
	Wetherby R.	30,760	64,424		
		140,200	156,995		

L

Div. No.	County Districts	Population (Estimated Mid. 1971)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
10	Goole B.	18,020	1,267	Dr. M. J. Lowe	6/7, Belgravia, Goole Tel. Goole 4216 and 2923
	Selby U.	11,620	3,848	Mr. R. Towell	
	Goole R.	9,450	36,776	Miss C. J. Badcock	
	Selby R.	10,230	32,909		
		49 320	74,800		
11	Castleford B.	38,140	4,394	Dr. J. F. Fraser	" Castledene," Pontefract Road, Castleford Tel. Castleford 4201 AND Baghill House, Walkergate, Pontefract Tel. Pontefract 3291
	Pontefract B.	31,120	4,865	Mr. W. Carver	
	Featherstone U.	15,270	4,424	Mrs. M. Craig	
	Knottingley U.	16,510	2,835		
	Normanton U.	17,630	3,067		
	Osgoldcross R.	9,110	33,954		
		127,780	53,539		
13	Morley B.	44,660	9,494	Dr. G. Ireland	Corporation St., Morley Tel. Morley 7021/4
	Ossett B.	17,380	3,333	Mr. A. Wright	
	Horbury U.	8,960	1,280	Miss A. Hibbard	
	Wakefield R.	24,210	21,344		
		95,210	35,451		
15	Batley B.	42,300	4,457	Dr. W. M. Douglas	Health Centre, Greenside, Cleckheaton Tel. Cleckheaton 3501/4 AND Market Place, Batley Tel. Batley 3141
	Spenborough B.	41,120	8,251	Mr. P. Marshall	
	Heckmondwike U.	9,470	696	(D.N.O. Vacant)	
	Mirfield U.	17,020	3,394		
		109,990	16,798		
18	Brighouse B.	34,370	7,873	Dr. S. H. Brock	Lawson Road, Brighouse Tel. Brighouse 2515 AND Abraham Ormerod Medical Centre, Todmorden Tel. Todmorden 2495
	Todmorden B.	15,040	12,789	Mr. H. Marshall	
	Elland U.	17,780	5,946	Miss C. J. Barker	
	Hebden Royd U.	8,730	7,084		
	Queensbury and Shelf U.	10,680	2,795		
	Ripponden U.	4,900	13,289		
	Sowerby Bridge U.	16,230	5,763		
	Hepton R.	3,360	21,758		
		111,090	77,297		

Div. No.	County Districts	Population (Estimated Mid. 1971)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
20	Colne Valley U.	21,170	16,054	Dr. J. P. Stuart	6/8, St. Peter's Street, Huddersfield HD1 1DH Tel. Huddersfield 29526/8
	Denby Dale U.	11,330	10,165	Mr. G. A. Beatson	
	Holmfirth U.	19,370	17,648	Mrs. S. North	
	Kirkburton U.	19,580	13,847		
	Meltham U.	6,720	5,906		
	Saddleworth U.	20,680	18,485		
		98,850	82,105		
22	Hoyland Nether U.	15,810	1,998	Dr. F. C. Armstrong	Mortomley Hall, High Green, Sheffield S30 4HR Tel. High Green 292
	Penistone U.	8,200	5,593	Mr. P. Fullwood	
	Stocksbridge U.	13,360	4,630	Mrs. M. Orr	
	Penistone R.	7,440	29,002		
	Wortley R.	40 740	48,130		
		85,550	89,353		
23	Hemsworth U.	14,740	4,163	Dr. J. S. Walters	Adiscombe House, Barnsley Road, Hemsworth Tel. Hemsworth 610377/8
	Hemsworth R.	51,380	29,019	Mr. G. Ellis	
				Miss D. Marsh	
		66,120	33,182		
25	Cudworth U.	8 800	1,746	Dr. C. G. Oddy	33 Queen's Road, Barnsley Tel. Barnsley 2247/8
	Darfield U.	7,780	2,018	Mr. L. S. Wrigg	
	Darton U.	15,300	4,717	Miss M. E. Pilling	
	Dodworth U.	4,550	1,857		
	Royston U.	8 870	1,423		
	Wombwell U.	17.970	3,838		
	Worsbrough U.	15,380	3,420		
		78,650	19,019		
26	Conisbrough U.	16 800	1,593	Dr. D. J. Cusiter	Dunford House, Wath upon Dearne Tel. Rotherham 872251/2
	Dearne U.	25,090	3,888	Mr. P. Goddard	
	Mexborough U.	15,800	1,452	Miss V. Dunford	
	Rawmarsh U.	19,820	2,600		
	Swinton U.	15,000	1,718		
	Wath upon Dearne U.	15,030	2,677		
		107.540	13,928		
27	Adwick le Street U.	17,890	3,605	Dr. R. Stalker	Arndale Centre, Doncaster Tel. Doncaster 61571
	Bentley with Arksey U.	22 690	4,950	Mr. C. W. Vallance	
	Tickhill U.	3,330	5,580	Miss D. M. E. Goldthorpe	
	Doncaster R.	81,060	75,093		
		124,970	89,228		

Div. No.	County Districts	Population (Estimated Mid. 1971)	Acreage	Divisional Medical Officer, Divisional Administrative Officer and Divisional Nursing Officer	Address of Divisional Health Office
29	Thorne R.	39,780	38,419	Dr. G. Higgins Mr. J. T. Howitt Miss C. J. Badcock	Council Offices, P.O. Box 4, Thorne Tel. Thorne 3130
31	Maltby U. Kiveton Park R. Rotherham R.	13,970 26 940 67.870	4,788 20,070 28,856	Dr. J. T. Clow Mr. A. Hill Mrs. A. Brooks	" Edenthorpe," Grove Road, Rotherham Tel. Rotherham 3131/2
		108,780	53,714		

Table 36 Dental Services for Expectant and Nursing Mothers and children under 5 years

Attendances and Treatment

	Children 0—4 (incl.)	Expectant and Nursing Mothers
First Visit	1,208	339
Subsequent Visits	982	884
Additional Courses of Treatment commenced	98	21
Number of Fillings	1,553	768
Teeth Filled	1,423	685
Teeth Extracted	1,602	621
General Anæsthetics	657	129
Emergencies	271	61
Patients X-Rayed	11	32
Prophylaxis	167	159
Teeth otherwise conserved	138	—
Teeth Root Filled	—	9
Inlays	—	4
Crowns	—	2
Courses of Treatment completed	1,177	241

Prosthetics

Patients supplied with F.U. or F.L. (First Time)	56
Patients supplied with Other Dentures	57
Number of Dentures supplied	158

Anæsthetics

General Anæsthetics administered by Dental Officers	777

Inspections

	Children 0—4 (incl.)	Expectant and Nursing Mothers
Number of First Inspections	A. 1,594	D. 356
Number in A. and D. requiring treatment	B. 1,245	E. 340
Number in B. and E. offered treatment	C. 1,242	F. 340

Sessions

Number of sessions devoted to M. & C.W. patients

For Treatment	516
For Health Education	7

Table 37 Antenatal Relaxation Classes

No. of sessions:	
(a) separate	4,302
(b) combined with antenatal clinics	95
Total ...	4,397
No. of women attending:	
(a) hospital booked	5,411
(b) domiciliary booked	730
Total ...	6,141
Total number of attendances:	
(a) hospital booked	26,504
(b) domiciliary booked	2,575
Total ...	29,079

Table 38 Ortolani Testing for Congenital Dislocation of the Hip—Summary of tests carried out, 1965-71

	1965	1966	1967	1968	1969	1970	1971
(a) Cases referred to specialist, confirmed as congenital dislocation of the hip and splinted	17	52	69	64	62	89	142
No. included in (a) referred by staff employed by the Authority	9	27	31	27	21	31	79
(b) Cases referred to specialist and said not to be congenital dislocation of the hip ...	31	62	43	78	61	108	237
(c) Cases referred to specialist, not splinted but given further review appointments	13	24	18	35	45	62	173

Table 39 Premature Babies

Total adjusted live births—30,687 Number of live premature births—1,913 Number born dead— 221 Percentage of premature live births to total live births—6·2

Weight Group	Number of Premature Births						Number Dying														Number Surviving over 28 days					Percentage Survival 1971	Percentage Survival in previous years					
	Born Alive					Born Dead	First Week							Second Week							over 14 up to 28 days											
lb.	A	B1	B2	C	Total		1	2	3	4	5	6	7	8	9	10	11	12	13	14		A	B1	B2	C	Total		1970	1969	1968	1967	1966
5—5½	42	2	279	495	818	20	9	1	4	2	1	1	—	—	—	—	—	—	—	—	2	41	2	272	483	798	97·6	97·1	97·8	97·1	96·7	98·0
4½—5	33	1	143	274	451	28	9	1	3	1	1	2	1	—	1	—	—	—	—	—	—	33	1	140	258	432	95·8	94·7	95·5	95·8	94·7	94·7
4—4½	11	—	75	161	247	17	12	7	1	2	2	—	—	—	1	1	—	—	—	—	—	11	—	60	150	221	89·5	91·4	93·4	92·0	89·7	91·2
3½—4	7	—	56	97	160	34	13	5	6	3	1	1	—	—	—	—	—	—	—	—	—	5	—	48	78	131	81·9	73·5	81·9	81·6	84·1	80·8
3—3½	5	—	21	70	96	27	15	2	4	—	—	—	—	—	—	—	—	—	1	—	1	3	—	19	51	73	76·0	66·1	72·3	57·3	72·4	63·5
2½—3	3	—	14	33	50	28	13	1	1	—	—	—	—	—	—	1	—	1	—	—	3	3	—	8	19	30	60·0	46·3	54·2	38·9	57·1	48·5
2—2½	5	—	9	30	44	28	24	3	3	2	2	—	1	—	—	—	—	—	—	—	—	—	—	3	6	9	20·5	23·4	28·8	20·7	24·1	21·7
1½—2	4	—	3	26	33	24	22	7	1	—	—	—	1	—	—	—	—	—	—	—	1	1	—	—	—	1	3·0	—	8·8	3·2	—	6·9
1½ and under	2	—	—	12	14	15	13	—	—	—	—	—	—	—	—	—	—	1	—	—	—	—	—	—	—	—	—	—	—	—	5·9	—
Total	112	3	600	1198	1913	221	130	27	23	10	7	4	3	—	2	2	—	2	1	—	7	97	3	550	1045	1695	88·6	86·3	88·9	86·6	87·8	87·2

204 7

218

A —Born in Domiciliary Practice.
B1—Born in Private Nursing Home.
B2—Born in Maternity Home.
C —Born in General Hospital.

The weight groups in the first column of this table should be read as under :
" 5—5½ lb." means " Over 5 lb. up to and including 5½ lb."
" 4½—5 lb." means " Over 4½ lb. up to and including 5 lb."
The remaining weight groups should be read in the same way

Table 40 Distribution of Welfare Foods

Year	National Dried Milk (Packets)	Cod Liver Oil (Bottles)	Vitamin A & D Tablets (Packets)	Orange Juice (Bottles)	Vitamin A, D & C Drops (Bottles)
1967	81,351	28,835	24,038	442,498	—
1968	72,262	28,314	22,018	405,803	—
1969	52,771	26,595	22,727	447,379	—
1970	43,393	26,049	24,432	494,497	—
1971	38,783	16,351	19,814	536,351	34,576

As from 4th April, 1971, the provision of cheap welfare milk for expectant mothers and young children ceased. After 30th April, 1971, the issue of Cod Liver Oil was not regarded as being part of the Welfare Foods Scheme. Issues of Vitamin A, D & C Drops commenced on 4th April, 1971, as part of the Welfare Foods Scheme.

Table 41 Midwifery—Hospital and Domiciliary Confinements

Division No.	Area	Population (Estimated mid-1971)	Total notified births (Live and Still)	Place of Birth					
				Hospital				Domiciliary	
				No.	No. of Early Discharges			No.	%
					At 48 hours	After 48 hours up to and including 5th day	After 5th but before 10th day		
1	Skipton	81,510	1,089	1,061	38	121	703	28	3
3	Keighley	55,720	949	932	15	246	531	17	2
4	Shipley	72,380	1,142	1,081	195	102	541	61	5
5	Horsforth	129,920	1,971	1,876	285	321	1,058	95	5
7	Harrogate	118,280	1,612	1,568	314	309	448	44	3
9	Rothwell/Wetherby	140,200	2,484	1,918	536	454	279	566	23
10	Goole	49,320	860	717	114	135	138	143	17
11	Castleford/ Pontefract ...	127,780	2,302	1,889	262	455	758	413	18
13	Morley	95,210	1,749	1,413	328	212	375	336	19
15	Spenborough ...	109,910	2,106	1,987	209	270	616	119	6
18	Calder Valley ...	111,090	1,783	1,417	67	131	97	366	21
20	Colne Valley ...	98,850	1,648	1,496	44	141	223	152	9
22	Wortley	85,550	1,579	1,473	228	291	688	106	7
23	Hemsworth ...	66,120	1,208	931	70	205	565	277	23
25	Barnsley	78,650	1,362	1,057	35	83	631	305	22
26	Wath	107,540	1,994	1,771	29	619	235	223	11
27	Doncaster	124,970	2,285	2,157	120	820	204	128	6
29	Thorne	39,780	750	667	102	191	52	83	11
31	Rotherham ...	108,780	2,213	1,975	513	714	399	238	11
Leeds Hospital Board Region		1,256,290	20,903	18,286	2,477	3,102	6,332	2,617	13
Sheffield Hospital Board Region		545,270	10,183	9,100	1,027	2,718	2,209	1,083	11
West Riding Administrative County		1,801,560	31,086	27,386	3,504	5,820	8,541	3,700	12

Table 42 Domiciliary Midwifery—Analgesia

Div. No.	Area	Percentage receiving Analgesia			
		Pethidine alone	Trilene alone	Trilene with Pethidine	Total
1	Skipton	11	18	63	92
3	Keighley	—	13	80	93
4	Shipley	18	28	45	91
5	Horsforth	15	37	13	65
7	Harrogate	7	28	30	65
9	Rothwell/Wetherby	21	26	32	79
10	Goole	17	50	22	89
11	Castleford/Pontefract	20	19	35	74
13	Morley	13	25	40	78
15	Spenborough	3	31	45	79
18	Calder Valley	18	20	38	76
20	Colne Valley	17	22	47	86
22	Wortley	52	13	14	79
23	Hemsworth	30	19	29	78
25	Barnsley	22	26	26	74
26	Wath	21	25	28	74
27	Doncaster	16	12	52	80
29	Thorne	39	13	39	91
31	Rotherham	28	17	24	69
	Leeds Hospital Board Region	18	25	35	78
	Sheffield Hospital Board Region	27	20	29	76
	West Riding Administrative County	21	23	33	77

Table 43 Health Visiting

Excluding their work in schools and general practitioners' surgeries, health visitors dealt with a total of 182,689 cases. Details are given below of the various case categories; where appropriate, cases have been included under more than one heading.

	Cases	
Expectant mothers	2,692	
Children born in 1971	30,487	
Children born in 1970	30,645	
Children born in 1966-69	60,464	
Persons aged 65 and over	23,560	(includes 8,861 visited at the special request of a general practitioner or hospital)
Mentally disordered persons	586	(includes 289 visited at the special request of a general practitioner or hospital)
Persons, excluding maternity cases, discharged from hospital (other than mental hospitals)	2,535	(includes 1,769 visited at the special request of a general practitioner or hospital)
Other cases	33,288	
Visits to tuberculous households	2,256	
Visits to households on account of other infectious diseases	1,758	

Health visitors attended 44,820 clinic sessions. Details are given below of the various clinics.

Type of Clinic	*No. of Sessions*
Child health (infant welfare)	28,719
Screening for infant deafness	6,092
Cervical cytology	1,730
Vaccination and immunisation	3,172
Ultra violet light	16
Minor ailments	797
Cardiac	8
Pædiatric	446
Family planning	580
Ophthalmic	1,686
Orthopædic	63
Ear, nose and throat	80
Diabetic	204
Chest	561
Geriatric	430
Others	236
Health Education—	
Mothercraft and relaxation groups	2,161*
Mothers' Clubs	333
Schools	1,688
Parent/Teacher groups	24
Other groups and organisations	588

A total of 39,589 hours was spent in schools and 11,666 home visits were made in connection with school health activities.

See also Table 37—Antenatal Relaxation Classes

Table 44 Home Nursing—Total Cases Visited

Types of cases attended	No. of cases attended	No. of visits by Home Nurses
Medical	27,432	660,456
Surgical	10,283	192,677
Infectious diseases...	428	2,421
Tuberculosis	193	7,586
Maternal complications	802	6,781
Others	433	3,830
Totals ...	39,571	873,751
Age groups		
0—4...	1,605	8,848
5—64	15,298	273,578
65 years and over	22,668	591,325
Totals ...	39,571	873,751
Patients included in the above who have had more than 24 visits during the year	9,144	590,188

Table 45 Home Nursing—Completed Cases

Classification of Cases by Disease:

Disease	No. of Cases
Tuberculosis	134
Other infectious diseases	444
Parasitic diseases	170
Malignant and lymphatic neoplasms	2,217
Asthma	156
Diabetes mellitus	545
Anæmias	1,909
Vascular lesions affecting central nervous system	1,694
Other mental and nervous diseases	699
Diseases of the eye	149
Diseases of the ear	398
Diseases of heart and arteries	1,713
Diseases of veins	1,079
Upper respiratory diseases	828
Other respiratory diseases	2,324
Constipation	1,191
Other diseases of digestive system	2,657
Diseases of urinary system and male genital organs	979
Diseases of breast and female genital organs	787
Complications of pregnancy and puerperium	772
Diseases of skin and subcutaneous tissues	1,541
Diseases of bones, joints and muscles	1,168
Injuries	2,267
Senility	1,135
Other defined and ill-defined diseases or disabilities	1,599
Diseases not specified	684
Total	29,239

Nursing Treatment:

Type	
Injections	6,089
General Nursing	6,920
Enemas	1,350
Dressings	8,698
Bed baths	916
Wash-outs, douches, etc.	410
Changing of pessaries	99
Preparation for diagnostic investigation	466
Others	4,291
Total	29,239

The total number of cases receiving injections was 6,858 but, in some cases, the injections were given during the course of a general nursing visit.

Injections: Type	No. of Cases
Insulin	303
Drugs for anæmia, debility, etc.	2,659
Antibiotics	2,032
Drugs for cardio-renal diseases	246
Others	1,618
Total	6,858

Referral of Cases: Source	
General practitioners	23,575
Hospitals	4,350
Health department staff	894
Others	420
Total	29,239

Disposal of Cases:	
Convalescent	15,640
Transferred to hospital	4,781
Died	3,684
Others	5,134
Total	29,239

Table 46 Ambulance Service

	1971		1970		1971 to 1970	
	Patients	Miles	Patients	Miles	Patients	Miles
Direct Service ...	753,594	4,614,638	715,805	4,487,602	+ 37,789	+127,036
Agencies ...	39,925	335,581	38,364	344,409	+ 1,561	— 8,828
Hospital Car Service ...	11,652	333,133	9,784	276,327	+ 1,868	+ 56,806
Total	805,171	5,283,352	763,953	5,108,338	+41,218	+ 175,014

Table 47 Ambulance Service - Accidents Attended

Type of Accident	Number of Accidents	Number of Patients
Road	4,625	6,747
Street	1,485	1,522
Works	1,335	1,355
Home	6,011	6,041
School	643	652
Sport	607	622
Drowning	8	8
Miscellaneous	255	261
Total	14,969	17,208

Table 48 Health Education - Summary of Activities

Subject	Estimated Audience			
	Clinics	Schools	*Other	Total
Ante and Post Natal, Childbirth ...	9,339	4,475	190	14,004
Child Development	6,618	2,509	155	9,282
Personal and Dental Hygiene	3,369	17,432	522	21,323
Personal Relationships including V.D. ...	1,045	11,529	3,392	15,966
Accident Prevention	5,665	5,494	4,660	15,819
Vaccination and Immunisation	162	40	—	202
Nutrition, Food, Hygiene, General Health	1,290	11,218	1,591	14,099
Cancer Education	3,026	7,585	1,857	12,468
Family Planning	199	102	266	567
Local Health Services	260	679	2,014	2,953
Aged	—	91	32	123
First Aid and Home Nursing	—	1,030	207	1,237
Totals ...	30,973	62,184	14,886	108,043

*Includes Mothers' Clubs, Women's Institutes, Guides, Scouts, Youth Clubs, St. John Cadets, Darby and Joan Clubs, etc.

Table 49 Provision of Nursing Equipment in the Home

Item	Total No. available for loan	No. of issues during year
Bath lift	1	—
Bath seats	50	66
Bedding: blankets, pillows and cases, sheets, etc.	1,393	834
Bed blocks	118	62
Bed cradles	812	1,175
Bed pans	2,286	3,500
Bed rests	1,086	1,832
Bed tables	18	11
Bedsteads: hospital, with self-lifting pole, and other	363	523
Chairs: geriatric, relaxing, high rest, 'Amesbury' play, stairway (carrying), etc.	78	78
Commodes: chair and other	1,316	2,484
Cushions: air and 'Dunlopillo'	362	634
Enuresis alarms	428	1,566
Fracture boards	152	192
Hydraulic hoists	58	84
Lifting pole and chain	71	100
Mattresses: various types	590	807
Rubber/Plastic sheets	1,886	2,170
Tables: 'Amesbury' play	1	2
Walking aids: 'Amesbury', 'Bonaped', 'Zimmer', tripod, 'Companion', 'Fordham', 'Mycroft', 'Welwyn', 'Winchester', etc., crutches and walking sticks	2,400	3,572
Wheelchairs: bath, folding, junior, self-propelled, spinal, stairway, etc.	789	1,931
Miscellaneous	163	204

Table 50 Chiropody Treatment

	Voluntary Association Schemes	Direct Service by County Council	Total
Number of sessions held:			
In voluntary association premises	2,886	—	2,886
In clinic premises	—	12,987	12,987
	2,886	12,987	15,873
Number of patients treated:			
In chiropodists' surgeries:			
Pensioners	2,034	8,628	10,662
Physically handicapped	37	168	205
Expectant mothers	—	4	4
In voluntary association or clinic premises:			
Pensioners	6,104	23,739	29,843
Physically handicapped	110	463	573
Expectant mothers	1	12	13
Domiciliary treatment:			
Pensioners	2,263	14,296	16,559
Physically handicapped	78	693	771
Expectant mothers	—	—	—
Total number of patients treated	10,627	48,003	58,630
Total number of treatments given:			
Pensioners	44,304	220,860	265,164
Physically handicapped	744	5,019	5,763
Expectant mothers	1	27	28
	45,049	225,906	270,955
Number of patients treated per session	9·0	8·4	8·5
Percentage of total patients treated receiving domiciliary treatment	22·0	31·2	29·6
Percentage of aged population receiving treatment (men over 65 years and women over 60 years)	4·0	18·1	22·1

Table 51 Milk (Special Designation) Regulations, 1963 and Milk (Special Designation) (Amendment) Regulations, 1965—Dealers Licensed

Number of Licence Holders	Dealing in pre-packed milk			
	Untreated	Pasteurised	Sterilised	Ultra Heat Treated
3,164	604	1,692	2,479	267

Table 52 Milk (Special Designation) Regulations, 1963 and Milk (Special Designation) (Amendment) Regulations, 1965—Details of Samples obtained from Dealers in the County Area

Untreated			Pasteurised					Sterilised		Ultra Heat Treated	
Methylene Blue Test			Phosphatase Test		Methylene Blue Test			Turbidity Test		Colony Count	
Satisfactory	Unsatisfactory	Void	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory	Void	Satisfactory	Unsatisfactory	Satisfactory	Unsatisfactory
1,990	212	173	1,903	11	1,776	61	77	42	—	143	—

Table 53 Milk (Special Designation) Regulations, 1963 as amended—Licensed Establishments for Pasteurising and Ultra Heat Treatment of Milk.

PASTEURISED MILK:

Chappell, R. M., Nether End Farm, Denby Dale.
Co-operative Retail Services Ltd., Doncaster Branch, York Road, Doncaster.
Co-operative Retail Services Ltd., Goole Branch, Centenary Road, Goole.
Crawshaw, J., Blake Lea Dairy, 103, Arksey Lane, Bentley.
Doxey, C., The Dairy, Nutwell Lane, Armthorpe.
Mawer, C., Glentworth House, Skellow.
Platts, N. H. & Sons, Home Farm, Bretton.
Rotherham Dairies Ltd., Progress Drive, Bramley.
Salmon, P., Ashbrooke, Littlethorpe, Ripon.
Snowden, F., Lumb Mill Farm, Crosshills.

ULTRA HEAT TREATED MILK:

Settle Creamery Ltd., New Road, Settle

Table 54 Milk (Special Designation) Regulations, 1963 as amended—Details of Samples obtained from Licensed Processing Plants

Pasteurised					Ultra Heat Treated	
Phosphatase Test		Methylene Blue Test			Colony Count	
Satis-factory	Unsatis-factory	Satis-factory	Unsatis-factory	Void	Satis-factory	Unsatis-factory
565	6	529	8	34	93	—

Table 55 Details of County Premises with Private Supplies of Water

Premises	Source of Supply
Aldfield C.E. School, Aldfield, near Ripon	Untreated trunk main—candle filter
Arncliffe School, Arncliffe, Skipton	Land spring—untreated
Askham Bryan Agricultural College, Askham Bryan, near York	Bore—untreated
Beamsley Boyle and Petyt Primary School, Beamsley, Skipton	Land spring—untreated
Clapham C.E. J.M.I. School, Clapham, Settle ...	Lake supply—chlorinated
Clint Burnt Yates Endowed School, Burnt Yates, near Harrogate	Bore—untreated
Colne Valley Wilberlee J.M.I. School, Slaithwaite ...	Land spring—untreated
Cracoe Rylstone District J.M.I. School, Cracoe, Skipton	Land spring—untreated
Grantley Hall Adult College, near Ripon	Land spring—filtered and chlorinated
Ingleborough Hall Special School, Clapham, Settle ...	Lake water—filtered and chlorinated
Laverton Dallowgill J.M.I. School, Kirkby Malzeard, near Ripon	Land spring—untreated
Long Preston Endowed J.M.I. School, Long Preston, Skipton	Land spring—untreated
Martons Both Endowed J.M.I. School, East Marton, Skipton	Land spring—filtered and chlorinated
Rathmell C.E. J.M.I. School, Rathmell, Skipton ...	Land spring to private reservoir—untreated
Ripley Endowed J.M.I. School, Ripley, near Harrogate	Land spring—filtered and chlorinated
Slaidburn Brennand's Endowed J.M.I. School, Slaidburn, near Clitheroe	Land spring—filtered and chlorinated

Table 56 Details of Applications for Grants under the Rural Water Supplies and Sewerage Acts, 1944-61

County District or Other Body	Description of Scheme	Date of Application	Estimated Cost of Scheme £
Calderdale Water Board	Far Sowood and Beestonley Lane, Stainland, Water Supply	3rd March	7,990
ditto	Lower Chiserley, Wadsworth, Water Supply	18th March	433
Colne Valley U.D.	Scammonden Water Supply and Sewerage	8th June	135,000
Craven Water Board	Newby and Cold Cotes Water Supply	17th March	17,000
Cudworth U.D.	Storrs Mill Farm, Sewerage and Sewage Disposal	14th December	20,000
Doncaster R.D.	Whiphill Lane, Armthorpe, Sewerage	9th July	10,000
Garforth U.D.	Garforth Sewerage and Sewage Disposal Phase III	5th October	375,113
Holmfirth U.D.	Water Supply to Moorcock and Hallingreave areas	7th September	14,564
Kirkburton U.D.	Manor Drive, Flockton, Sewerage	24th September	1,064
ditto	Houses Hill, Kirkheaton, Sewerage	ditto	2,295
ditto	Upper Ozzings, Shelley, Sewerage	ditto	654
ditto	Knotty Lane, Lepton, Sewerage	ditto	970
ditto	Heaton Hall, Kirkheaton, Sewerage	ditto	498
ditto	Hey Moor, Shepley, Sewerage	ditto	578
ditto	Shelley Woodhouse, Sewerage	1st November	37,520
Kiveton Park R.D.	Woodsetts, Sewer Extension	8th October	6,000
Nidderdale R.D.	Hampsthwaite and Killinghall Sewerage	2nd December	334,600
Osgoldcross R.D.	Darrington, Stapleton and Womersley Main Drainage	3rd February	250,000
Ripon City	Ripon Central Area Main Drainage	6th May	574,000
Ripon and Pateley Bridge R.D.	Littlethorpe Sewerage	8th December	18,697
Selby R.D.	Camblesforth, Carlton and West Bank Sewerage and Sewage Disposal	3rd May	4,342
ditto	Drax Sewerage and Sewage Disposal	9th August	127,350
Skipton R.D.	East and West Marton Sewerage and Sewage Disposal	11th February	38,565
Stocksbridge U.D.	Pen Nook and Hollin Busk Main Drainage	17th November	135,000
Wharfedale R.D.	Leathley, High Mills (Pool) and Castley Sewerage	20th October	139,850

Table 57 School Swimming Pools

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Aireborough Grammar	30,000	Conventional	Sand	Chlorine Gas	—
Armthorpe Junior	12,400	Conventional	Diatomaceous Earth	Automatic Chlorinator	—
Aston Lodge C.P.	10,500	Learner	Diatomaceous Earth	Automatic Chlorinator	Pool in planning stage
Bardsey Primary	870	Constructed	Diatomaceous Earth	Automatic Chlorinator	—
Bewerley Park Centre for outdoor pursuits	12,000	Constructed	Diatomaceous Earth	Automatic Chlorinator	—
Bingley Grammar	46,400	Conventional	Diatomaceous Earth	Automatic Chlorinator	—
Bishopthorpe C.E.	12,000	Constructed	Sand	Automatic Chlorinator	Pool opened 1971
Boroughbridge County Primary	6,000	Learner	Diatomaceous Earth	Drip Feed	—
Bridge House Special School, Harewood	4,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Brighouse Woodhouse Junior	8,800	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Collingham C.E.	10,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Copmanthorpe J.M.	8,000	Learner	Sand	Automatic Chlorinator	—
Darton Barugh J.M.I.	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Darton Kexbrough	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Dinnington High	90,000	Conventional	Sand	Automatic Chlorinator	Pool in planning stage
Ermysted's Grammar Skipton	29,000	Conventional	Sand	Chlorine Gas	—
Featherstone R.C.	46,000	Conventional	Sand	Chlorine Gas	—
Garforth Ninelands	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1971
Goole RiversideE.S.N.	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1971
Harrogate Granby Park	52,000	Conventional	Sand	Chlorine Gas	—
Harrogate Woodlands	20,000	Conventional	Diatomaceous Earth	Automatic Chlorinator	—
Harthill with Woodhall C.P.	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1971
Hartwith Summerbridge	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Hebden Royd Centre, Pitt Street, Hebden Bridge	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Horbury C.E.	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Horbury Bridge C.E.	8,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Horsforth Featherbank	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Horsforth Two Dales School and Adult Training Centre	5,400	Constructed	Sand	Automatic Chlorinator	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Hoyland Common J.M.I.	6,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Ilkley Grammar	35,000	Conventional	Sand	Chlorine Gas	—
Ilkley Menston Primary	25,000	Constructed	Sand	Drip Feed	—
Keighley Oakbank Grammar	60,500	Conventional	Diatomaceous Earth	Chlorine Gas	—
Kippax North	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1971
Kirkburton Turnshaws School and Adult Training Centre	7,000	Conventional	Sand	Automatic Chlorinator	Pool in planning stage
Kirk Fenton Parochial	8,000	Learner	Sand	Automatic Chlorinator	—
Meltham C.E.	15,000	Constructed	Diatomaceous Earth	Automatic Chlorinator	—
Mexborough C.E.	9,600	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Mexborough Grammar	18,000	Learner	Diatomaceous Earth	Drip Feed	—
Ossett Comprehensive	—	—	—	—	Pool in planning stage
Penistone St. John's C. E.	8,000	Learner	Canvas Bags	Drip Feed	Pool not used
Rawcliffe Tall Trees School and Adult Training Centre	8,000	Learner	Sand	Automatic Chlorinator	—
Ripon Grammar	52,000	Conventional	Sand	Chlorine Gas	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Rothwell Carlton J.M.I.	8,000	Learner	Sand	Drip Feed	—
Scawthorpe Secondary	50,625	Conventional	Sand	Chlorine Gas	—
Scholes J.M.I.	8,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Scissett Miners Welfare Club	70,000	Constructed	Sand	Chlorine Gas	Joint ownership with Denby Dale U.D.C.
Shade C.P. Todmorden	30,000	Conventional	Sand	Chlorine Gas	—
Sherburn in Elmet	8,000	Learner	Sand	Drip Feed	—
Stourton C.P.	8,000	Learner	Sand	Automatic Chlorinator	—
Swillington J.M.	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1971
Tadcaster J.M.	8,000	Learner	Sand	Automatic Chlorinator	—
Thorpe Arch C.E.	13,000	Conventional	Sand	Automatic Chlorinator	—
Thorne Grammar	48,000	Constructed	Diatomaceous Earth	Automatic Chlorinator	—
Thrybergh J.M.	14,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Todwick J.M.	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1971
Ulleskelf C.E.	6,000	Learner	Canvas Bags	Drip Feed	—
Upper Poppleton C.P.	2 pools 2,000 14,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Upper Wharfedale Secondary	43,000	Conventional	Diatomaceous Earth	Automatic Chlorinator	—

School	Pool		Filtration	Chlorination	Remarks
	Capacity in gallons	Type			
Upton - North Elmsall J.M.I.	21,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
Wales C.P.	8,000	Learner	Sand	Automatic Chlorinator	Pool in planning stage
Ward Green J.M.I., Worsbrough	12,000	Learner	Diatomaceous Earth	Automatic Chlorinator	—
West Ardsley Redwood Croft School and Adult Training Centre	9,000	Constructed	Sand	Automatic Chlorinator	Pool opened 1971
Weston Lane C.P., Otley	7,000	Constructed	Sand	Added by hand	—
Whinburn Special School, Keighley	5,000	Learner	Canvas Bags	Drip Feed	—
Whiston C.P.	8,000	Learner	Sand	Automatic Chlorinator	Pool opened 1971
Worsbrough Bank End	8,000	Learner	Sand	Automatic Chlorinator	—
Worsbrough Birdwell C.P.	13,000	Constructed	Diatomaceous Earth	Automatic Chlorinator	—

Table 58 Atmospheric Pollution

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Micrograms per cubic metre			Micrograms per cubic metre		
Barnoldswick—Health Department, Fernlea, surrounding district residential and commercial with railway nearby	67 for 9 months	439	10	86 for 9 months	413	20
Keighley — First floor of Public Health Department in built-up area in centre of town	72 for 11 months	439	7	109	649	11
Keighley—Branshaw View, 20ft. above ground in classroom on south-west side of building, $\frac{1}{4}$ mile south-west of town centre. Surrounding district residential	45 for 11 months	297	1	54	434	2
Bingley — Health Department, Town Hall, 1/5th mile outside town centre, surrounding district parkland	45 for 8 months	261	5	89 for 8 months	372	5
Shipley—Health Department, Town Hall, surrounding district residential and commercial	55	405	5	121	689	16
Horsforth—Broadway, in residential area, most properties to the south in Smoke Control Areas	46	438	2	93	560	10
Otley–First floor of Council Offices, in town centre, mainly manufacturing	36 for 10 months	224	3			
Harrogate — Ground floor of Municipal Offices, surrounding district residential and commercial	46	316	2	70	339	0

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Micrograms per cubic metre			Micrograms per cubic metre		
Harrogate — Ground floor of Regional Office, Milk Marketing Board, surrounding district residential and manufacturing	75	337	12	74	336	0
Knaresborough–Knaresborough House, in parkland surrounded by mixed residential and commercial properties, open country to west	50	331	2	51	295	6
Goole—Health Department, Municipal Offices, Stanhope Street, surrounding area commercial, residential and shipping	76	613	10	66	275	14
Selby—Council Depot in residential and commercial area	70	455	5	98	377	7
Castleford—First floor of Divisional Health Office, in residential area of industrial town	220 for 7 months	767	13	112 for 3 months	207	74
Castleford—The Green, Ferry Fryston—situated 12ft. above ground on E. side of the Pavilion, surrounding district residential with open country to E.	181 for 8 months	761	9	109 for 3 months	395	21
Castleford — Slaughterhouse in Superintendent's office, 20ft. above ground, surrounding district, residential and commercial	69 for 5 months	444	9	115 for 1 month	237	28
Normanton—Neville House. Surrounding district commercial, residential and a few small factories	131	835	9	178	594	21

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity* Microgrammes per cubic metre	Highest Value	Lowest Value	Average Daily Concentration SO_2* Microgrammes per cubic metre	Highest Value	Lowest Value
Pontefract—Municipal Offices. In laboratory on second floor in mixed commercial and manufacturing area	117	639	10	130	636	21
Pontefract—Moverley Flatts. In rear storeroom of Council Depot, surrounding district residential	169	931	10	144	539	Alk.
Pontefract—Carleton Park. First floor landing of flats in residential area	110	682	4	117	541	Alk.
Horbury—Ground floor lobby of Town Hall, facing east 12ft. above ground, surrounding district residential and manufacturing	70	886	8	135	898	31
Morley—Public Health Inspector's Department, Commercial Street, surrounding district residential, commercial and manufacturing	63 for 9 months	468	2	113 for 9 months	472	34
Morley—Spring Avenue, Gildersome in residential area	62	526	2	129	501	36
Ossett—Seemore Arcade. Surrounding district residential and commercial	75	980	7	147	890	28
Batley—Public Health Department, Market Place, in centre of mixed residential, commercial and manufacturing district	112	1,049	13			
Spenborough—Health Centre, Greenside, in small park, residential and commercial area	74	850	2	144	798	31

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Micrograms per cubic metre			Micrograms per cubic metre		
Elland–Council Offices, 20ft. above ground in manufacturing area	69	728	3	115	811	17
Hebden Royd (Mytholmroyd)—Redacre Sewage Works, residential and manufacturing area, open country to north	48	303	2	60	343	Alk.
Hebden Royd (Hebden Bridge)—On second floor landing of Council Offices, in centre of mixed residential, commercial and manufacturing district	64 for 10 months	357	4	106 for 10 months	454	10
Sowerby Bridge—Crow Wood Park, in parkland in residential area	42 for 11 months	315	5	102 for 11 months	317	Alk.
Sowerby Bridge—Ryburn Secondary School in open country	52 for 11 months	301	2	99 for 11 months	352	18
Todmorden—In first floor room on south side of Medical Centre, surrounding district mixed residential, commercial, manufacturing and open country	61	506	7	122	603	19
Colne Valley—Town Hall, Cross Street, Slaithwaite, in mixed residential and textile manufacturing district	80	841	8	124	876	Alk.
Denby Dale—Public Health Inspector's Office, surrounding district mixed residential, manufacturing and open country	101	824	4	117	563	30

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity* Microgrammes per cubic metre	Highest Value	Lowest Value	Average Daily Concentration SO_2* Microgrammes per cubic metre	Highest Value	Lowest Value
Denby Dale—Emley C.P. School. In village in open country	65 for 9 months	377	6	106 for 9 months	273	35
Holmfirth—On second floor landing of Council Offices, surrounding district open country, residential, commercial and manufacturing	86	835	17	143	1,182	38
Kirkburton—Town Hall in mainly residential and manufacturing area	79 for 11 months	883	5	82 for 11 months	641	0
Saddleworth–Sewage Works, Shaw Hall Bank, Greenfield, surrounding district residential, manufacturing and commercial	58	499	7	74	444	Alk.
Wortley (Grenoside)–Health Dept., Council Offices, surrounding area industrial and manufacturing	18 for 8 months	109	1	93 for 8 months	342	23
Wortley (Oughtibridge)—County School, Church Street, surrounding district industrial and manufacturing	39 for 11 months	862	2	68 for 11 months	574	Alk.
Hemsworth—Divisional Health Office, Adiscombe House, in residential area	153 for 8 months	854	12	128 for 8 months	472	7
Hemsworth—Brierley Hall in residential area	82	545	1	114	544	6
Hemsworth — Grimethorpe, in residential commercial and manufacturing area	101	830	2	139	627	39
Hemsworth—Ackworth, in clinic in a residential area	143 for 3 months	469	23	112 for 3 months	248	53

*For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Micrograms per cubic metre			Micrograms per cubic metre		
Hemsworth—South Kirkby in residential, commercial and light industrial area	142 for 11 months	898	12	151 for 11 months	797	27
Darton—Council Offices, in semi-residential colliery district. Coke by-product plant 1 mile to S.E.	156	927	11	78	199	17
Wombwell—The Gables, semi-residential colliery district	187 for 9 months	1,186	20	103 for 9 months	194	31
Wombwell—The Library, Station Lane, surrounding district residential and commercial	175 for 9 months	1,019	27	118 for 9 months	296	25
Worsbrough—Savile House —8ft. above ground in outbuilding, rear of Council Offices. Surrounding country open and low density residential	126	1,530	11	107	587	19
Worsbrough—Blacker Hill in open residential area, colliery to N.W., coke ovens to W.	150 for 2 months	714	44	153 for 2 months	488	29
Conisbrough–Denaby Clinic, in room facing north. Surrounding district residential —high density	177 for 6 months	960	34	187 for 6 months	464	65
Conisbrough—The Priory, in staff dining room facing west. Surrounding district residential—low density	117 for 10 months	971	12	120 for 10 months	434	38
Rawmarsh—Public Health Inspector's Office, in centre of residential and industrial area	143 for 11 months	2,147	17			

* For period of full year unless stated otherwise.

Situation of Instrument	Smoke			Volumetric SO_2		
	Average Daily Suspended Impurity*	Highest Value	Lowest Value	Average Daily Concentration SO_2*	Highest Value	Lowest Value
	Micrograms per cubic metre			Micrograms per cubic metre		
Wath upon Dearne—Town Hall, in commercial and residential area with industrial zone 1-2 miles N. to N.E.	96	852	8	130	656	18
Bentley with Arksey—Health Department, Chapel Street, semi-residential colliery district	106	922	7	125	459	13
Doncaster (Barnby Dun)—Barnby Dun School, in residential area 5 miles north-east of Doncaster C.B.	72	471	3	92	396	16
Doncaster (Askern)—In Askern Clinic 6 miles south of Doncaster with open country to the south, residential to the north-east, heavy industry to north-west	66	577	6	150	850	26
Thorne—Council Offices, in semi-residential colliery district	80	450	16			

*For period of full year unless stated otherwise.

Table 59 Certification and Treatment of Blind and Partially Sighted Persons

The following table gives particulars of new registrations during the period ended 31st December, 1971, of Blind and Partially Sighted Persons (other than handicapped school children).

	Disability (B = Blind PS = Partially Sighted)									
	Cataract		Glaucoma		Retrolental Fibroplasia		Others		Total	
	B	PS	B	PS	B	PS	B	PS	B	PS
(i) No. of cases registered during the year in which Section F. recommends										
(a) No treatment				No figures available					11	117
(b) Medical (Medical, Surgical, Optical or Ophthalmic Medical Supervision)	176*	91**	47	12	1	—	117	74	341	177
(ii) No of cases (i) (b) above which received treatment	109	53	38	8	1	—	67	42	215	103

* includes 35 cases of cataract with glaucoma
** includes 19 cases of cataract with glaucoma

Table 60 Registration of Nursing Homes

Div. No.	Name and Address of Nursing Home	Number of beds registered	
		Maternity	Other
1	" Christony ", Eshton Hall, Gargrave	—	48
3	Sunnybank, Braithwaite, Keighley	—	9
3	Norwood House, High Spring Gardens Lane, Keighley ...	—	14
5	Oak Bank, Outwood Lane, Horsforth	—	13
5	Jesmond, New Street, Farsley	—	7
5	St. Joseph's Convalescent Home, Outwood Lane, Horsforth...	—	45
5	Ardenlea, Queen's Drive, Ilkley (Marie Curie Memorial Foundation)	—	33
5	Hanford House, 22, Margerison Road, Ben Rhydding, Ilkley	—	7
7	Cavendish, 17, Cavendish Avenue, Harrogate...	—	17
7	Duchy House, 9, Queen's Road, Harrogate	—	35
7	The Pines, 57, Harlow Moor Drive, Harrogate	—	14
7	Norman Lodge, 58, Kent Road, Harrogate	—	29
7	Westfield, Killinghall, Harrogate	—	9
7	Courtfield, 3, St. James's Drive, Harrogate	—	14
7	Hereford, 16, Hereford Road, Harrogate	—	22
7	Kingsley, 38, Ripon Road, Harrogate	—	26
7	Ellangowan, 26, Queen's Road, Harrogate	—	17
7	Heatherwood, 17, Duchy Road, Harrogate	—	14
7	Clova, 1, Clotherholme Road, Ripon	—	21
7	Hampden House, 120, Duchy Road, Harrogate	—	46
7	Edenfield, 3, Tewit Well Road, Harrogate	—	32
7	Warwick, 10, Warwick Crescent, Harrogate	—	9
9	Cheshire Home, Spofforth Hall, Spofforth, Harrogate ...	—	28
15	Cheshire Home, Kenmore, Whitcliffe Road, Cleckheaton ...	—	27
20	Woodend, Atherton Street, Springhead	—	13

Table 61 The Medical Inspection of School Children

NUMBER OF PUPILS ON REGISTERS

Nursery full-time	380
Nursery part-time	382
Primary	199,386
Secondary	121,975
Special Schools (Boarding)	330
Special Schools (Day)	2,083
Special Schools (Hospital)	127
Total	324,663

TABLE I

MEDICAL INSPECTION OF PUPILS ATTENDING MAINTAINED PRIMARY AND SECONDARY SCHOOLS (INCLUDING SPECIAL SCHOOLS)

A.—Periodic Medical Inspections

Age groups inspected (by year of birth) and number of pupils examined in each, together with classification of the physical condition of the pupils inspected.

Age groups inspected (Year of Birth)	Number of Pupils who have received a full medical examination	Physical Condition of Pupils Inspected		Number of Pupils found not to warrant a medical examination (See Note below)
		Number Satisfactory	Number Unsatisfactory	
(1)	(2)	(3)	(4)	(5)
1967 and later ...	5,833	5,832	1	—
1966 ...	13,980	13,954	26	—
1965 ...	8,063	8,034	29	—
1964 ...	2,051	2,040	11	475
1963 ...	2,204	2,199	5	4,760
1962 ...	1,792	1,784	8	3,528
1961 ...	1,338	1,333	5	3,209
1960 ...	1,202	1,197	5	3,466
1959 ...	583	583	—	3,211
1958 ...	344	343	1	741
1957 ...	2,646	2,625	21	5,043
1956 and earlier ...	3,027	2,967	60	6,325
Total ...	43,063	42,891	172	30,758

Column (3) total as a percentage of Column (2) total ... 99·60%

Column (4) total as a percentage of Column (2) total... 0·40%

NOTE: As selective examinations have been carried out, Column (5) above gives the number of pupils who have been 'interviewed' or 'discussed' at case conferences and found not to warrant a medical examination.

B.—Other Inspections

Number of Special Inspections	13,480
Number of Re-Inspections ...	6,196
Total ...	19,676

The number of children examined during 1971 shows a decrease on the 1970 figures:

Year	Periodics	Other Inspections	Number of pupils found not to warrant an examination on Selective Procedures
1970	46,397	17,970	29,126
1971	43,063	19,676	30,758

C.—Pupils Found to Require Treatment

Number of individual pupils found at Periodic Medical Inspection to require treatment (excluding Dental Diseases and Infestation with Vermin).

Group (Year of Birth)	For defective vision excluding squint	For any of the other conditions recorded in Table III	Total individual pupils
1967 and later	95	293	371
1966	315	1,134	1,384
1965	230	644	837
1964	69	129	187
1963	117	327	409
1962	80	193	235
1961	69	116	182
1960	87	155	229
1959	44	72	107
1958	13	30	42
1957	128	258	364
1956 and earlier	185	375	542
Total	1,434	3,726	4,889

Table II

Infestation with Vermin

(i)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	496,869
(ii)	Total number of individual pupils found to be infested	11,060
(iii)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	400
(iv)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	25

The percentage of infested pupils found during 1971 was 3·10 as opposed to a percentage of 3·20 in 1970.

Table III

Defects found by Medical Inspection in the Year Ended 31st December, 1971

NOTE.—All defects noted at medical inspection as requiring treatment are included in this table, whether or not this treatment was begun before the date of the inspection

Defect Code No.	Defect or Disease	Periodic Inspections						Special Inspections	
		Entrants		Leavers		Total (including all other periodic age groups inspected)		Requiring treatment	Requiring observation
		Requiring treatment	Requiring observation	Requiring treatment	Requiring observation	Requiring treatment	Requiring observation		
4	Skin	222	702	183	157	521	1,060	251	232
5	Eyes—a. Vision	693	1,299	294	512	1,423	2,396	402	1,280
	b. Squint	301	581	12	54	362	736	49	234
	c. Other	23	119	6	44	36	218	29	62
6	Ears—a. Hearing	221	818	76	72	410	1,164	262	469
	b. Otitis Media	73	601	10	53	110	737	73	155
	c. Other	38	124	25	16	76	155	58	53
7	Nose and Throat	347	1,681	52	123	511	2,127	119	553
8	Speech	218	850	2	23	301	1,000	157	296
9	Lymphatic Glands	19	571	1	8	26	648	2	84
10	Heart	41	439	16	65	86	594	27	247
11	Lungs	131	640	16	95	199	903	70	358
12	Developmental—								
	a. Hernia	42	112	—	2	51	133	11	38
	b. Other	74	677	79	49	195	854	46	301
13	Orthopædic—								
	a. Posture	11	104	6	23	22	158	13	41
	b. Feet	107	591	39	63	216	849	63	282
	c. Other	55	332	11	74	90	493	53	163
14	Nervous System—								
	a. Epilepsy	31	89	20	35	71	175	37	104
	b. Other	50	557	16	51	105	772	38	182
15	Psychological—								
	a. Development	28	370	3	25	96	573	364	396
	b. Stability	34	731	14	60	108	1,040	336	492
16	Abdomen	33	138	9	24	70	211	12	43
17	Other	194	755	57	55	357	979	120	743

Table IV

Treatment of Pupils

Notes

The figures given under this heading include:

(i) cases treated or under treatment during the year by members of the Authority's own staff;

(ii) cases treated or under treatment during the year in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Boards;

(iii) cases known to the Authority to have been treated or under treatment elsewhere during the year.

Figures under this section are incomplete as one has to rely on hospital discharge notifications and other agencies.

	Number of cases known to have been dealt with
Group 1. Eye Disease, Defective Vision and Squint	
External and other, excluding errors of refraction and squint	474
Errors of refraction (including squint)	17,727
Total	18,201
Number of pupils for whom spectacles were prescribed	5,668
	Number of cases known to have been treated
Group 2. Diseases and Defects of Ear, Nose and Throat	
Received operative treatment:	
(a) for diseases of the ear	188
(b) for adenoids and chronic tonsillitis	1,002
(c) for other nose and throat conditions	235
Received other forms of treatment	367
Total	1,792
Total number of pupils in schools who are known to have been provided with hearing aids:	
(a) in 1971	37
(b) in previous years	279
Group 3. Orthopædic and Postural Defects	
(a) Pupils treated at clinics or out-patient departments	581
(b) Pupils treated at school for postural defects	72
Total	653

	Number of cases known to have been treated
Group 4. Diseases of the skin (excluding uncleanliness for which see Table II)	
Ringworm—(a) Scalp	4
(b) Body	12
Scabies	487
Impetigo	273
Other skin diseases	541
Total	1,317
Group 5. Child Guidance Treatment	
Number of pupils treated at Child Guidance clinics under arrangements made by the Authority	2,386
Group 6. Speech Therapy	
Number of pupils treated by Speech Therapists under arrangements made by the Authority	2,779
Group 7. Other Treatment Given	
(a) Number of cases of miscellaneous minor ailments treated by the Authority	1,335
(b) Pupils who received convalescent treatment under School Health Service arrangements	9
(c) Pupils who received B.C.G. vaccination	20,701
(d) Other:	
1. Ultra Violet Light Treatment	11
2. Audiology	134
3. Abdominal defects	2
4. Chest and Heart	88
Total (a)—(d)	22,280

Table 62 Care of the Handicapped Pupil

The following table gives details of handicapped pupils and particulars of the number of children receiving special education:

Category	Total Ascertained	Number receiving special education				Awaiting Placement
		In special schools		Otherwise than at school	Total receiving Special Education	
		County schools	Other schools			
Blind	52	—	47	1	48	4
Partially Sighted... ...	54	—	49	1	50	4
Deaf and Partially Hearing	238	5	224	—	229	9
Physically Handicapped...	353	—	295	29	324	29
Delicate	107	63	37	1	101	6
Maladjusted	148	57	36	3	96	52
Educationally Subnormal	2,818	2,267	265	1	2,533	285
Epileptic	31	—	30	—	30	1
Speech Defects	6	—	3	—	3	3
Totals	3,807	2,392	986	36	3,414	393

Table 63 Audiology Clinics

Summary of Work Carried Out

Otley Clinic

Number of Sessions held	8
Number of Individual Children attending	
(a) Referred for first time in current year...	14
(b) Also attended in previous year	5
Total	19
Total number of attendances made	31
Areas from which referred (i.e. number from each Division)	
Division No. 5	19
Total	19
Ages of children referred	
Under 1	—
1—2 years	—
2—5 years	5
5—8 years	11
8—11 years...	3
11+ years	—
Results of Clinical Investigation	
Number of children with significant hearing loss	4
Number of children without significant hearing loss	13
Number of children at present undiagnosed	2
Recommendations	
Hearing aid ordered by the E.N.T. Consultant	3
Front seat in class	1
Speech Therapy required	2
School for the Deaf	—
School for the Partially Hearing	—
Referred to E.N.T. Consultant	6
Special supervision by the Peripatetic Teacher	3

Doncaster Clinic

Number of Sessions held	35
Number of Individual Children attending	
(a) Referred for first time in current year...	89
(b) Also attended in previous year	45
Total	134
Total number of attendances made	153
Areas from which new cases referred (i.e. number from each Division)	
Division No. 11	7
Division No. 13	1
Division No. 23	2
Division No. 25	1
Division No. 26	14
Division No. 27	55
Division No. 29	9
Total	89
Ages of children referred	
Under 1	1
1—2 years	4
2—5 years	17
5—8 years	40
8—11 years...	16
11+ years	11
Results of Clinical Investigation	
Number of children with significant hearing loss	71
Number of children without significant hearing loss	55
Number of children at present undiagnosed	8
Recommendations	
Hearing aid ordered by the E.N.T. Consultant	13
Front seat in class...	17
Speech therapy required	10
School for the Deaf	3
School for the Partially Hearing	5
Referred to E.N.T. Consultant	41
For special supervision by Peripatetic Teacher	25
To be seen by Psychologist	43
To be referred to Psychiatrist	1
To spend half a day in the Nursery Department of the Y.R.S.D.	3

Table 64 The Work of the Psychologists

Children Seen

Maladjusted

Age Range

	Below 5	5—7+	8—10+	Over 11	Totals
Boys ...	19	145	202	254	620
Girls ...	13	48	69	122	252
Totals ...	32	193	271	376	872
% age ...	4	22	31	43	

Symptoms on Referral

	Nervous	Behaviour	Habit	Others	Totals
Boys ...	137	414	54	21	626
Girls ...	71	157	17	7	252
Totals ...	208	571	71	28	878
% age ...	24	65	8	3	

Children with Handicaps other than Maladjustment referred for Psychological Assessment

Age Range

	Below 5	5—7+	8—10+	Over 11	Totals
Boys ...	79	323	364	200	966
Girls ...	50	172	141	84	447
Totals ...	129	495	505	284	1,413

Type of Handicap

	Vision	Hearing	Speech	Motor	Learning	General Back-wardness	Others	Totals
Boys ...	12	64	53	41	429	273	94	966
Girls ...	7	42	7	18	111	212	50	447
Totals	19	106	60	59	540	485	144	1,413

VISITS

Schools	Special Schools	Homes	Audiology Clinics	Assessment Centres	Others
1129	206	138	36	173	75

Table 65 School Ophthalmic Service, 1956-71

Year	No. of children examined (including re-examinations)	No. prescribed glasses
1956	17,644	9,999
1957	17,662	9,782
1958	18,829	9,472
1959	18,784	9,411
1960	20,651	10,029
1961	20,387	9,542
1962	19,874	8,831
1963	20,559	9,201
1964	20,248	8,904
1965	20,304	8,590
1966	19,996	8,024
1967	20,167	7,649
1968	20,725	7,747
1969	20,052	7,221
1970	18,788	6,259
1971	18,201	5,668

Table 66 Medical Treatment at Local Authority Clinics

Type of Clinic	Number
Minor Ailment and other non-specialised	81
Dental	64
Ophthalmic	56
Speech Therapy	56
Ultra Violet Light	2
Pædiatric	10
Chiropody	2
Consultant E.N.T.	2
Consultant Orthopædic	7
Consultant Dermatology	—
Consultant Cardiac	—
Orthoptic	—
Remedial Exercises	6
Audiology	2
Immigrants	1
Enuretic	13
School Medical Officers' Special Examination	92

Table 67 Consultant Services

Consultant E.N.T. Service

No. of sessions held: 94

	Pre-school Children	School Children	Total
No. of individual children seen by consultant, including those continuing attendance from previous year	12	171	183
No. of above referred for operative treatment	7	78	85
No. of children:			
(a) who obtained operative treatment ...	17	118	135
(b) treated at school clinics	—	23	23
No. of attendances at consultant clinics ...	20	84	104

Consultant Orthopædic Service

Consultant Clinics

No. of sessions held: 78

No. of individual patients seen by consultant, including those continuing attendance from previous year	431	362	793
No. of above:—			
(a) referred for operative treatment as short stay cases only	5	9	14
(b) recommended long-stay hospital school	2	—	2
(c) recommended treatment by orthopædic nurse or physiotherapist:—			
(i) at treatment centres	1	11	12
(ii) domiciliary	6	6	12
No. of children who obtained operative treatment	2	3	5
Total number of attendances at consultant clinics	615	571	1,186

Treatment Centres

No. of sessions held: 450

Total No. of patients treated, including cases continuing treatment from previous year ...	14	142	156
Total number of attendances	187	1,809	1,996

Domiciliary Treatment

	Pre-school Children	School Children	Total
Total number treated	—	—	—
Total number of visits to patients' homes ...	—	—	—

Appliances

No. of appliances—			
(a) recommended	23	8	31
(b) obtained	23	8	31

Physiotherapy Service

At the end of the year the staff aggregated the equivalent of 0·59 whole-time officers.

Ultra Violet Light Clinics

Clinics are held in only two Divisions.

Number of sessions held: 108

Number of children treated during the year ...	2	19	21
Total number of attendances	101	371	472

Consultant Pædiatric Service

Consultant Clinics

No. of sessions held: 18

No. of individual patients seen—			
(a) New cases	13	13	26
(b) Cases attending from previous year(s) ...	12	47	59
Total number of attendances at clinics ...	31	69	100

The following table gives details of the various types of defect or disease for which children were referred for consultant opinion:

Defect or Disease	Pre-School Children	School Children	Total
Central Nervous System: General	—	—	—
Epilepsy	4	15	19
Migraine	—	1	1
Heart and Circulatory System	9	44	53
Respiratory System, including E.N.T. defects	4	19	23
Speech	—	1	1
Orthopædic	—	2	2
Scaphocephaly	—	1	1
Cerebral Palsy	2	1	3
Psychological: General	—	—	—
Behaviour	—	1	1
Mental Retardation, including Educational Subnormality	5	7	12
Congenital Deformities	5	8	13
Gastro-intestinal System	1	2	3
Genito-urinary System	2	6	8
Nutritional	6	5	11
Developmental: General	12	6	18
Incontinence	1	4	5
Muscular Disease	—	1	1
Habit Spasms	—	2	2
Obesity	1	1	2
Unclassified	10	6	16

Table 68 Cleanliness, 1952-71

Year	Total number of examinations made by school nurses	Number of individual children found to be infested	Percentage of school population
1952	610,201	19,772	8·1
1953	575,645	17,815	7·1
1954	549,961	13,619	5·3
1955	547,369	11,657	4·5
1956	512,868	10,379	3·9
1957	481,239	10,459	3·9
1958	523,353	9,753	3·7
1959	482,874	9,834	3·6
1960	467,937	10,341	3·9
1961	462,207	9,273	3·5
1962	421,257	8,912	3·3
1963	416,570	8,229	3·3
1964	434,790	8,696	2·0
1965	461 862	8,999	3·2
1966	478.017	7,786	2·7
1967	455,124	7,119	2·4
1968	446,713	7,980	2·6
1969	425,329	7,243	2·3
1970	440,376	10,292	3·2
1971	496,869	11,060	3·1

In some areas a system of 'Selective' inspections has been introduced as suggested in *The Health of the School Child*, 1962/63.

Table 69 Nutrition, 1959-71

Year	Total number of pupils inspected	Classification			
		Satisfactory		Unsatisfactory	
		No.	% of Col. 2	No.	% of Col. 2
(1)	(2)	(3)	(4)	(5)	(6)
1959	88,398	87,484	98·97	914	1·03
1960	83,630	82,892	99·12	738	0·88
1961	82,938	82,343	99·28	595	0·72
1962	82,395	81,950	99·46	445	0·54
1963	76,706	76,268	99·43	438	0·57
1964	70,895	70,485	99·42	410	0·58
1965	75,134	74,728	99·46	406	0·54
1966	73,122	72,836	99·61	286	0·39
1967	68,382	68,264	99·83	118	0·17
1968	59,315	59,187	99·78	128	0·22
1969	51,765	51,645	99·77	120	0·23
1970	46,397	46,163	99·50	234	0·50
1971	43,063	42,891	99·60	172	0·40

School Meals

The number of meals provided to school children daily according to a check made in September, 1971, was 189,111 compared with 210,416 in September, 1970. This represents 63·44 per cent. of children in attendance.

Table 70 Protection of School Children Against Tuberculosis

Tuberculin Testing of School Entrants

Health Division	No. tested	Negative reactions	Positive reactions	Of column (d)		Further investigation
				Previous B.C.G. Vaccination	Final Skin Test	
(a)	(b)	(c)	(d)		— +	
Keighley (Heaf Test)	819	793	26	15	— 11	Referred to Chest Physician.

Table 71 Speech Therapy

(a) Number of children seen for the first time during the year	1,276	
(b) Number of children attending for treatment from previous year ...	1,503	
	2,779	
Number of children awaiting treatment at end of year	1,151	
(a) Interviewed and placed on waiting list	652	
(b) Not seen	499	
Number of visits made to schools	2,000	
Number of home visits	329	
Analysis of children treated	*Boys*	*Girls*
Stammerers (Dysrhythmia)	195	56
Defects of Articulation due to:		
(a) Cleft Palate	33	20
(b) Cerebral Palsy	18	13
(c) Other structural malformations	109	46
(d) Other causes e.g. neurological	44	16
(e) No specific cause found	969	403
Disorders of Language due to:		
(a) Retarded language development (non-specific)	259	107
(b) Retardation with associated subnormality	145	96
(c) Retardation associated with deafness	30	25
(d) Dysphasia	17	6
(e) Aphasia	1	—
(f) Other reasons...	8	1
Dysphonia	5	3
Other Defects	4	4

Table 72 Dental Inspections and Treatment Carried Out

Attendances and Treatment

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First visit	26,777	28,884	6,364	62,025
Subsequent visits	33,899	63,895	14,913	112,707
Total visits	60,676	92,779	21,277	174,732
Additional courses of treatment commenced	1,842	2,049	662	4,553
Fillings in permanent teeth ...	36,335	82,758	23,786	142,879
Fillings in deciduous teeth ...	20,087	1,547	—	21,634
Permanent teeth filled	27,901	70,259	20,733	118,893
Deciduous teeth filled	18,057	1,424	—	19,481
Permanent teeth extracted ...	2,492	10,101	2,324	14,917
Deciduous teeth extracted ...	38,004	10,715	—	48,719
General anæsthetics	12,875	7,593	829	21,297
Emergencies	2,847	1,419	326	4,592

Number of Pupils X-rayed	3,730
Prophylaxis	17,718
Teeth otherwise conserved	2,234
Number of teeth root filled	431
Inlays	92
Crowns	529
Courses of treatment completed... ...	51,073

Orthodontics

New cases commenced during year ...	1,356
Cases completed during year	1,109
Cases discontinued during year	162
Number of removable appliances fitted...	2,900
Number of fixed appliances fitted ...	138
Pupils referred to Hospital Consultant ...	—

Prosthetics

	5 to 9	10 to 14	15 and over	Total
Pupils supplied with F.U. or F.L. (first time)...	3	8	10	21
Pupils supplied with other dentures (first time)	23	208	118	349
Number of dentures supplied	46	334	229	609

Anæsthetics General Anæsthetics administered by Dental Officers ... 20,781

Inspections

(a)	First inspection at school. Number of Pupils	173,717
(b)	First inspection at clinic. Number of Pupils	19,778
	Number of (a) + (b) found to require treatment	107,189
	Number of (a) + (b) offered treatment	91,972
(c)	Pupils re-inspected at school or clinic	15,584
	Number of (c) found to require treatment	7,569

Sessions

Sessions devoted to treatment	24,692*
Sessions devoted to inspection	1,235
Sessions devoted to Dental Health Education ...	325

*Includes 1,396 Anæsthetic sessions

FOOD AND DRUGS ACT, 1955

Report of County Analyst

During the year, 2,206 samples were submitted by your Inspectors under the Food and Drugs Act, 1955, as set out below:

	Total Samples	Adulterated or Below Standard	Percentage Adulterated or Below Standard
Milk	738	11	1·5
Milk, Channel Islands ...	112	2	1·8
Milk and Foreign Matter ...	3	3	100·0
Food and Drugs	1,353	67	4·9
All samples	2,206	83	3·7

NOTES ON ADULTERATED OR OTHERWISE IRREGULAR SAMPLES:

The proportion of adulterated and irregular samples was slightly higher than last year.

Milk. Seven hundred and thirty-eight samples were analysed. Only 11 were unsatisfactory. Nine were deficient in fat by amounts varying between 2·0 and 36·6 per cent. Two other samples contained 5·8 and 16·0 per cent. of added water respectively.

Channel Islands Milk. Out of 112 samples, two were below standard. Instead of the required 4·0 per cent. they contained only 3·49 and 3·78 per cent. fat.

Pork Sausages must contain at least 65 per cent. of meat, of which half must be lean. This is a safeguard against the inclusion of an undue proportion of fat. Only one sample was irregular in this respect; it contained only 26 per cent. of lean meat.

The average meat content of all samples was 70·7 per cent., individuals ranging from 65·0 to 91·3 per cent.

Four samples were adversely reported because they contained preservative without the proper declaration.

Beef Sausages must contain at least 50 per cent. of meat. Only one, containing 48·5 per cent. was below standard. The average meat content was 63·7 per cent., the lowest 48·5 per cent., the highest 80·8 per cent.

One sample contained undeclared preservative, and two contained excessive amounts of sulphur dioxide, namely 490 and 690 parts per million.

Colouring Matter in Food. All appropriate samples were examined for artificial colours. Only one contravention of the Regulations was discovered, a prohibited red dye in a soft drink powder.

Lime Cordial and Lager. As yet, there is no legal standard for the alcohol content of these shandy-type drinks. In my opinion it should not be below 1·5 per cent. proof spirit; one sample contained only 1·1 proof spirit.

Labelling of Foods. Labels are scrutinised for compliance with the *Labelling of Food Order, 1953*, and with regard to the provisions of the *Labelling of Food Regulations, 1970*, which come into force on 1st January, 1973.

Several packers are confused by the change-over to the new Regulations. On two packs of tinned fruit salad, the lists of ingredients were set out in alphabetical order, whereas they should have been stated in accordance with the order of proportions of the ingredients used.

In some labels we discovered mis-spellings of the names of the ingredients, and in others the terminology was confused.

Several pre-packed cheese preparations were incorrectly described e.g. 'Cream*ed* Cheese' which is not one of the descriptions prescribed by the *Cheese Regulations, 1970*. 'Cream Cheese' was found to be Full Fat Soft Cheese—quite a different article.

On a few labels the list of ingredients were incomplete.

Drugs. Ninety-two samples were examined. Only six were irregular; two samples of Indian brandee had obsolete references to the B.P.C. (British Pharmaceutical Codex). Two samples of baby cream were deficient in zinc oxide, whereas two of camphorated oil contained too much camphor.

Faulty Tinned Goods. The contents of a tin of cooked rice, and of a tin of processed slicing cheese were stained with rust owing to corrosion of the tinplate.

In a tin of 'Garden Peas' there was only green liquor—not a single pea!

Mouldy Foods. We received three of these samples, a sliced loaf, a salmon and tomato sandwich and a packet of sausages. All were adjudged unfit for human consumption.

Foods not up to standard. In addition to substandard milks and sausages, we received 'Double Cream' which was actually single cream, potted beef with only 75 per cent. meat (it should contain 95 per cent.), Bilberries in Water (too much water), Cheshire cheese with excess moisture, and Old English Butter Drops deficient in butter.

The purchaser of some Martini Vermouth Chocolates was very disappointed to find that they were simply empty chocolate shapes.

Malt Vinegar. One sample was proved to be Non-Brewed Condiment.

FOREIGN BODIES IN FOOD:

The presence of certain foreign objects in food is easily explained, for instance flying insects which are attracted by the sweetness, or when scorched fall into the food. We had several examples of this, namely wasps in a lemon tart and in a marshmallow slice, and a fly in a loaf of bread. It is more difficult to understand how a snail came to be baked in a loaf of bread.

Milk bottles are often misused, and deposits formed on the glass which resist the washing processes; if these are not detected, the bottles may be refilled with milk and become the subject of complaints. In one bottle there were patches of cement, and in two others there were deposits of soil and dust.

While eating chocolate dragees, a consumer discovered a sharp piece of metal in his mouth; we proved that it was a sliver of steel.

A whole spent match was found in a bag of flour; another unwelcome find was in a bottle of Sparkling Orange Drink—several lumps of broken glass and a broken bottle brush.

KEIGHLEY EXCEPTED DISTRICT

V. P. McDonagh, Borough School Medical Officer

This report is compiled in accordance with the arrangements made by the County Council of the West Riding of Yorkshire as to the School Health Service in the Borough of Keighley and details the work carried out during the year under review.

The Joint Assessment Clinic which was started last year at Airedale General Hospital continued to function to the advantage of all concerned. The child guidance work, as in recent years, occupied a large part of the time of one senior departmental medical officer together with the other members of the team, the psychologists, psychiatric social workers and health visitors. The investigations of the psychologists into the problems of reading backwardness were continued during the year and a lengthy report is presented of their findings. When considering reading difficulties the indiscriminate use of the term 'dyslexia' has caused confusion and has been further complicated by Section 27 of the *Chronically Sick and Disabled Persons Act, 1970*, which refers to 'acute dyslexia'. The reading difficulties to which the Act refers are not acute in the medical sense of coming sharply to a crisis; if, on the other hand, acute is meant in the lay sense of severe the Act omits to define the degree of severity. In the schools and the child guidance clinic the reading difficulties encountered may be termed more appropriately 'specific reading disabilities' and should be considered along with reading backwardness of all kinds. Early diagnosis is essential as there is often some degree of associated emotional disturbance. There is general agreement among those involved with this particular problem that children with a specific reading disability are best dealt with at special remedial centres where the staff, including child psychiatrists and educational psychologists, form a cohesive team. Unfortunately, despite several recommendations, we are still awaiting in Keighley the provision of a fully staffed remedial education centre.

In this report the Area Dental Officer again expresses his concern that the public water supply in Keighley contains only minimal amounts of flouride despite the strong scientific evidence that the addition of artificial fluoride would reduce considerably the amount of dental decay in the population.

The Medical Inspection of School Children:

The number of pupils on the registers at the end of the year is shown below together with the figures for the previous year:

	1971	*1970*
Nursery	45	188
Primary	5,895	5,710
Middle Schools	2,027	1,985
Voluntary Secondary	565	552
Upper Schools	1,392	1,413
Special Schools	165	99

Table I

Medical Inspection of Pupils attending Maintained Primary and Secondary Schools (including Nursery and Special Schools)

A. Periodic Medical Inspections

Age groups inspected (by year of birth), number of pupils who received a full medical examination together with classification of the physical condition of the pupils inspected, the number of pupils found not to warrant a medical examination in connection with the selective medical examinations and the number of pupils found to require treatment (excluding dental disease and infestation with vermin).

Age groups inspected (by year of birth)	Number of Pupils who have received a full medical examination	Physical Condition of Pupils Inspected		Number of Pupils found not to warrant a medical examination	Pupils found to require treatment (excluding dental diseases and infestation with vermin)		
		Satisfactory	Unsatisfactory		For defective vision (excluding squint)	For any other condition recorded in Table III	Total individual pupils
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
1967 and later	131	131	—	—	2	15	16
1966	686	686	—	—	23	124	134
1965	155	155	—	—	11	35	40
1964	11	11	—	—	1	7	7
1963	240	240	—	572	3	76	77
1962	78	78	—	106	1	25	25
1961	—	—	—	—	—	—	—
1960	—	—	—	—	—	—	—
1959	—	—	—	—	—	—	—
1958	—	—	—	—	—	—	—
1957	—	—	—	79	—	—	—
1956 and earlier	—	—	—	625	—	—	—
Total	1,301	1,301	—	1,382	41	282	299

Column (3) total as a percentage of Column (2) total ... 100·00%

Column (4) total as a percentage of Column (2) total ... 0·00%

B. Other Inspections

Number of Special Inspections	...	1,663
Number of Re-Inspections	...	1,023
Total	...	2,686

Comparative Table of Inspections carried out:

Year	Routine	Specials	Re-Inspections
1971	1,301	1,663	1,023
1970	1,255	1,691	747
1969	1,293	1,911	930
1968	1,313	1,963	1,074
1967	1,354	1,629	1,033

SELECTIVE SCHEME:

The selective scheme of medical examination of pupils in the intermediate age group has continued as described in previous reports. During the year 996 questionnaires were distributed of which 953 were returned and 318 of these pupils were invited to attend for a medical examination. Details of the defects found are shown in Table III.

School leaving examination of pupils during their last year of compulsory school attendance:

The selective scheme of examination of school leavers was continued in 1971 following the instigation of this procedure in 1967. Questionnaires were distributed to parents of school leavers for completion and return. These were scrutinised together with all the available medical records. At the medical interviews, which were held in the schools, pupils were selected for a full medical examination, to be carried out at the school clinic by appointment.

A total number of 704 pupils were interviewed in accordance with the provisions of this scheme. In no case, however, was it found necesary to invite a pupil to attend the school clinic for a fuller medical examination.

CONSULTING SESSIONS:

Consulting sessions are held twice weekly at the school clinic by a senior departmental medical officer. Appointments are given to parents, following school medical inspections, to bring their children to the school clinic for investigation and consultation if this is requested by the parents or advised by the senior departmental medical officer who has carried out the medical in-

spections in school. Pupils are also referred to these sessions by teachers, education welfare officers or are brought by the parents themselves for examination and consultation for a variety of health problems.

The poor school attender is referred frequently for the problem to be assessed and for decisions to be made regarding treatment, the need for special educational placement or for reassurance that a child is fit to attend school regularly.

Parents who are concerned about their child's general health, behaviour difficulties or disorders such as nocturnal enuresis frequently seek the advice of the senior departmental medical officer. If further investigation is considered to be necessary referral is made appropriately either to the family doctor, to a specialist, or to the child guidance clinic. Pupils also attend for advice concerning ear, nose and throat conditions, chest, orthopædic and skin conditions.

This consulting service is also available to pre-school children.

Table II

Infestation with Vermin

(a)	Total number of individual examinations of pupils in schools by the school nurses or other authorised persons	21,996
(b)	Total number of individual pupils found to be infested... ...	641
(c)	Number of individual pupils in respect of whom cleansing notices were issued (Section 54(2), Education Act, 1944)	—
(d)	Number of individual pupils in respect of whom cleansing orders were issued (Section 54(3), Education Act, 1944)	—

Table III

Defects Found by Periodic and Special Medical Inspections During the Year

Note.

All defects, including defects of pupils at Nursery and Special Schools, noted at periodic and special inspections are included in the following table, whether or not they were under treatment or observation at the time of inspection.

Defect Code No.	Defect or Disease	Periodic Inspections								Special Inspections	
		Entrants		Leavers		Others		Total			
		(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)	(T)	(O)
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
4	Skin	1	—	—	—	3	—	4	—	202	2
5	Eyes–a. Vision ...	37	1	—	—	4	1	41	2	22	1
	b. Squint ...	36	3	—	—	2	2	38	5	10	1
	c. Other ...	2	—	—	—	—	—	2	—	14	4
6	Ears–a. Hearing ...	26	1	—	—	31	10	57	11	177	47
	b. Otitis Media	1	1	—	—	—	—	1	1	38	2
	c. Other ...	29	—	—	—	—	—	29	—	47	—
7	Nose and Throat ...	31	13	—	—	6	4	37	17	34	4
8	Speech	36	4	—	—	12	2	48	6	88	8
9	Lymphatic Glands ...	2	—	—	—	—	—	2	—	—	—
10	Heart...	1	2	—	—	—	5	1	7	6	18
11	Lungs	17	2	—	—	3	3	20	5	40	17
12	Developmental–										
	a. Hernia ...	—	—	—	—	—	—	—	—	3	1
	b. Other ...	2	—	—	—	2	—	4	—	3	3
13	Orthopædic–										
	a. Posture ...	—	—	—	—	—	—	—	—	1	—
	b. Feet ...	4	—	—	—	1	—	5	—	39	—
	c. Other ...	9	1	—	—	2	2	11	3	43	2
14	Nervous System–										
	a. Epilepsy ...	3	2	—	—	—	2	3	4	24	14
	b. Other ...	—	1	—	—	1	1	1	2	8	7
15	Psychological–										
	a. Development	4	6	—	—	31	34	35	40	295	103
	b. Stability ...	4	6	—	—	31	34	35	40	307	91
16	Abdomen	1	—	—	—	—	—	1	—	4	2
17	Other...	11	2	—	—	1	3	12	5	31	6
18	Totals	257	45	—	—	130	103	387	148	1,436	333

T = Pupils found to require treatment O = Pupils found to require observation

Table IV

Treatment of Pupils

Notes

The figures given under this heading include:

(i) cases treated or under treatment during the year by members of the Authority's own staff;

(ii) cases treated or under treatment during the year in the Authority's school clinics under National Health Service arrangements with the Regional Hospital Board;

(iii) cases known to the Authority to have been treated or under treatment elsewhere during the year.

Figures under this section are incomplete as one has to rely on hospital discharge notifications and other agencies.

A. Eye Diseases. Defective Vision and Squint:

	Number of cases known to have been dealt with	
	1971	1970
External and other, excluding errors of refraction and squint ...	15	13
Errors of refraction (including squint)	—	—
Total	15	13
Number of pupils for whom spectacles were prescribed	—	—

Due to circumstances beyond our control the services of a consultant ophthalmologist were not available to pupils at the school clinic. Pupils requiring an ophthalmic examination during the year were referred to their family doctors for the examination to be arranged.

Screening Tests of Vision:

A vision screening test was carried out as part of the medical inspection of school entrants and routine tests of visual acuity were repeated in the 6-7, 10-11, 12-13 and 14-15 year age groups. A colour vision test was also undertaken in the 10-11 year age group and repeated if necessary in the older age groups. These tests are carried out by the assistant health visitors/school nurses and have been greatly facilitated by the use of the Keystone vision screening apparatus which has been particularly successful with school entrants.

General:

During the year 15 cases suffering from conditions of the eyes such as blepharitis and conjunctivitis were treated at the minor ailments clinic.

The number of repairs to and replacements of spectacles amounted to 154.

B. Diseases and Defects of Ear, Nose and Throat:

	Number of cases known to have been dealt with	
	1971	1970
Received operative treatment:		
(a) for diseases of the ear	—	—
(b) for adenoids and chronic tonsillitis	—	—
(c) for other nose and throat conditions	—	—
Received other forms of treatment	135	108
Total	135	108
Total number of pupils still on the register of schools at 31st December, 1971 known to have been provided with hearing aids:		
(a) during the calendar year 1971	1	
(b) in previous years	6	

SCREENING TESTS OF HEARING:

The routine audiometric testing of seven year old pupils was carried out by the assistant health visitors/school nurses during the year, together with the examination of pupils in the 'at risk' categories.

Following the audiometric sweep test of pupils in school a weekly clinic is held at the school clinic where pupils who fail the test are seen by appointment for the purpose of obtaining an audiogram and medical history. A further weekly clinic is held when a senior departmental medical officer is available to conduct an aural examination and select cases for referral to the consultant otologist. The family doctors are informed in the usual way or cases are referred to them in the instances where this is desired. There is good communication between the senior departmental medical officers, family doctors and consultant otologist.

Referral to the child guidance clinic is easily effected so that advice re educational requirements or emotional problems associated with hearing loss is readily available.

A total number of 49 pupils in attendance at Keighley schools are suffering from a bilateral hearing loss of 30 decibels or more. Hearing aids have been prescribed for seven of these pupils.

Pupils who are suffering from a bilateral hearing loss of 30 decibels or more and who are in attendance at the ordinary school are examined by the psychologist to assess their educational progress and needs for special educational help. As a result of these examinations it is found that partially hearing pupils are very much in need of the services of a specialist teacher of the deaf.

Pupils Tested by Pure-Tone Audiometry

	Number Tested	No appreciable hearing loss	Referral for investigation	Already attending Otologist
'At risk' categories				
(i) deafness in the family ...	3	3	–	–
(ii) prenatal causes:				
maternal rubella	–	–	–	–
other conditions	–	–	–	–
(iii) perinatal causes *e.g.* toxæmia, anoxia, kernicterus, rhesus incompatability, prematurity, etc.	–	–	–	–
(iv) postnatal:				
congenital defects ...	–	–	–	–
cerebral palsy	–	–	–	–
middle ear disease ...	24	9	13	2
meningitis or encephalitis	–	–	–	–
speech retardation or defect	3	1	2	–
educational retardation ...	13	10	3	–
Routine test on children in 6/7 year age group	1,107	1,091	11	5
Referred for possible hearing loss...	83	47	33	3
Total	1,233	1,161	62	10

During 1971 a pilot scheme to carry out an audiometric sweep test in school of pupils aged 10-11 years was conducted; the results were as follows:

No. of children tested	420
No. who failed initial test	43
No. with no appreciable loss on retest	29
No. who failed to attend for retest	10
No. already attending Otologist	2
No. referred to E.N.T. Surgeon	2

C. Orthopædic and Postural Defects:

	Number of cases known to have been dealt with	
	1971	1970
(a) Pupils treated at clinics or out-patient departments ...	116	142
(b) Pupils treated at school for postural defects	—	—
Total ...	116	142

JOINT ASSESSMENT CLINIC:

Following the opening of Airedale General Hospital in 1970, a joint assessment clinic has been held bi-monthly at the hospital with the senior departmental medical officers, physiotherapists, speech therapists, Dr. Morgan, consultant pædiatrician and Mr. Cape, consultant orthopædic surgeon. This clinic enables all persons concerned with the care and treatment of physically handicapped pupils to exchange opinions on the individual cases and has proved to be advantageous to the patients and professional staff.

PHYSIOTHERAPY:

The physiotherapist has continued to treat severely handicapped children at the school clinic in addition to the usual remedial work. As in previous years treatment has also been carried out at the swimming baths and as a result of the increase in the number of children requiring this treatment, two sessions a week were held instead of one as in previous years. Assistance has also been given with the children from Whinburn Special School at their swimming class. The results of these classes have proved most satisfactory and fully justify the time and effort put into them.

The following shows details of the work undertaken by the physiotherapist.

School Children	No. of Cases	Attendances
Breathing	55	770
Cerebral palsy (other)	6	135
Curly toes	8	53
Foot exercises	33	463
Manipulations	3	3
Muscular dystrophy	1	38
Posture	4	58
Remedial exercises	4	63
Round shoulders	1	1
Spina bifida	1	34
Pre-school Children		
Breathing	3	16
Cerebral palsy	5	104
Foot exercises	4	42

	Pre-school Children	School Children
Treatment Centres:		
Number of sessions held	450	
Total number of patients treated (including cases continuing treatment from previous year)	12	116
Total number of attendances	162	1,618
Domiciliary Treatment:		
Total number treated	—	—
Total number of visits to patients' homes	—	—
Appliances:		
Number of appliances—(a) recommended	—	—
(b) obtained	—	—

D. Diseases of the Skin (excluding uncleanliness for which see Table II):

	Number of cases known to have have been treated	
	1971	1970
Ringworm—(a) Scalp	—	—
(b) Body	—	—
Scabies	93	110
Impetigo	53	68
Other skin diseases	49	189
Total	195	367

It will be seen from the figures that the incidence of scabies has decreased during the year. As previously, affected children have been treated at the school clinic, child contacts have also received treatment at the clinic and their homes visited by the health visitors/school nurses. Adult contacts have been advised and provided with a supply of benzyl benzoate or 'Quellada' for their own treatment. School inspections have been carried out but there has been little evidence of any spread of infection within the schools. Infection has occurred mostly in the homes and between relatives and neighbours.

A weekly clinic is held for the treatment of plantar warts.

E. Child Guidance Treatment:

	Number of cases known to have been treated	
	1971	1970
Pupils treated at Child Guidance Clinics	199	208

Location of clinic:

School Clinic,
147, Skipton Road,
Keighley.

Number of sessions held during the year 191

	Boys	*Girls*	*Total*
Number of new cases seen...	50	26	76
Total number of cases discharged or admitted for residential treatment	54	22	76
Number of cases carried forward...	86	37	123

In 1971 the staff of the child guidance clinic remained basically the same as in 1970, i.e. a senior departmental medical officer as physician in charge, two psychologists and a psychiatric social worker. In February the services of the mental welfare officer were withdrawn and replaced by an experienced assistant health visitor/school nurse.

As in previous years the children attending the clinic with their parents have included pre-school children, physically and mentally handicapped children and children suffering from behaviour, nervous and habit disorders. Activities have included the counselling of parents in the clinic and in their homes, the treatment of children at the clinic including psychotherapy and play therapy and the counselling of teachers in the schools.

The child guidance clinic forms an integral part of the School Health Service in Keighley. The physician in charge is closely associated with every aspect of the school health service and the psychologists have undertaken the psychometric examinations of pupils prior to the full examinations by one or other of the senior departmental medical officers for the purpose of ascertaining those pupils who are in need of special education. The psychologists have also made frequent visits to schools to discuss the educational problems of the pupils they have examined. The psychiatric social worker and the physicians in charge have also visited schools to discuss problems of behaviour and personality difficulties and the assistant health visitor/school nurse is a frequent visitor in the schools engaged in school health duties.

The following tables relate to the number of children seen by the psychologists during the year including those attending the child guidance clinic and those who were examined for the purposes of ascertainment.

Total number of children seen by psychologists

Age	—5	5—7+	8—10+	11+	Total
Boys	12	30	32	24	98
Girls	14	14	15	9	52
Total	26	44	47	33	150

Total number of children seen by psychologists, classified according to major handicap.

	Hearing	Vision	Speech	Motor	Learning	General Backward-ness	Malad-justment	Total
Boys	8	1	1	3	12	50	23	98
Girls	5	3	—	6	2	27	9	52
Total	13	4	1	9	14	77	32	150

The mental health of children at school is the concern of the school medical officer and one aspect of mental health is that a pupil should be able to benefit from his education and fulfil his potential. Failure at school is a known cause of secondary emotional disturbance and attention is given to determine whether in fact a child is fulfilling his potential as ascertained by psychological examination. The need for a remedial centre has been stressed for several years in this report to cater for the needs of those children who constantly fail in the ordinary school. The recommendation "special education in the ordinary school" is made to draw attention to the requirements of these children.

During 1971 a small survey was carried out by one of the psychologists to ascertain what progress had been made by these pupils for whom this recommendation had been made. A report on the survey was published in *Well-being*, 1972, *2*, 43. The results of the survey are given below and indicate that whilst many children have benefitted by the remedial help which has been given within the ordinary school, there are still some for whom special provision needs to be made. The survey stresses that provision is needed for the child of average intelligence who is seriously underfunctioning in the ordinary school and who is a mental health 'risk'.

Survey of Children Recommended for Special Education in the Ordinary School:

The survey covered only the five years 1966 to 1970.

A total number of 113 pupils were known to be in this category—79 boys and 34 girls—over the period. Annual figures for boys were steady at 14 to 19 in each year. The number of girls varied widely from 2 to 12 in any one year.

The age at examination varied from 6 to 13 years. The mean age at examination was 8 years 7 months. The girls' ages were steady over the period; the boys' ages increased from 7 years 7 months in 1966 to 9 years 1 month in 1970.

Based on about half the cases, the average waiting period between referral and examination was 57 days.

Mean intelligence quotients were surprisingly high:

Boys	Girls	Total
91·4	91·6	91·5

If the intelligence quotient is taken as the criteria, then only about a third of the children could be classed as 'slow learners'.

The reading test on Form 3 H.P. was available for some of the children. Mean reading ages on this test were:

Boys	Girls
5·34 years	5·48 years

Mean reading quotients calculated from these reading ages were:

Boys	Girls
65·27	68·80

A number of pupils were re-tested during the Autumn Term of 1971. Pupils who had spent less than a year in school since the senior departmental medical officer's examination were excluded but otherwise an attempt was made to see every child who had previously had a reading test. Seventy-two were re-tested altogether—48 boys and 24 girls.

Reading age had increased in every case. Because of the wide variation in ages, reading quotient is a more meaningful figure and the difference in reading quotient from the first to the second test was taken as a fair measure of improvement.

The mean increase in reading quotient was 2·28 points. The pupils taken altogether were functioning slightly better in the second test than they were in the first. The best increased their reading quotients by over 30 points but the worst lost 20 points and more during the interval.

Reading quotient does not allow for the widely differing learning periods of individual children so that a measurement of the actual rate of learning seemed necessary. Each child's increase in reading age was divided by the length of time which had elapsed between the two reading tests.

The resulting ratio is a comparison with the reading of the 'average' child, who makes one year's reading progress in one year.

The mean rate of learning for the 72 children re-tested was 0·74—i.e. on average 9 months progress was made per year. Again, many made much more progress; many made much less.

If children have become retarded they must obviously make more than average progress to 'catch up'. Rate of learning must be more than 1·0.

Only 18 children were making progress at a rate of 1·0 or better. This is exactly a quarter of the children re-tested. The other three quarters were not making 'remedial' progress but were slipping further behind their year-group at varying rates.

To elucidate the factors associated with remedial progress, tests of significance (X^2) were applied. Age, length of learning period and intelligence quotients were not significantly associated with real progress (i.e. a rate of 1·0 or better).

To date, a significant degree of association with progress has only been found with two factors: 'Junior School attended' and 'Middle School attended'. It seems likely that the Middle School factor owes something to the Junior School factor.

It is not known whether the schools concerned have the advantage of smaller classes or better organisation or more interest in the retarded but it is encouraging to know that schools can and do make a difference.

SPECIAL EDUCATION IN THE ORDINARY SCHOOL:

Number of new cases examined by a senior departmental medical officer or psychologist during 1971 and considered as being in need of special education 24

Number of cases examined and considered to be in need of special education in previous years and still in attendance at school 131

Total number of children who have been examined and are considered to be in need of special education in the ordinary school ... 155

F. Speech Therapy:

	Number of cases known to have been treated	
	1971	1970
Pupils treated by speech therapists	286	213

In 1971 the speech therapy service was widened as a result of the employment of two additional part-time therapists. Mrs. Bateman took up her duties in August giving two sessions a week and Mrs. Bray in November giving three sessions a week. Speech therapy has been given to the pupils at Braithwaite Day Special School and Whinburn Residential Special School one session each week and occasional sessions have been held at Branshaw View Day Special School.

The following shows details of the work undertaken by the speech therapists.

1.	Number of half-day sessions held during the year		266
2.	(a) Number of children seen for the first time during the year ...		128
	(b) Number of children attending for treatment from previous year		158
	Total number of children treated		286
3.	Number of children awaiting treatment at end of year		21
	(a) Interviewed and placed on waiting list		3
	(b) Not seen		18
4.	Children discharged during the year:	Boys	Girls
	Total	39	25
	Analysis		
	Speech normal	13	14
	Speech improved	14	6
	Unsuitable for treatment	2	—
	Non co-operation	2	—
	Admitted to special schools	2	1
	Left school	3	1
	Left district	3	3
	Other reasons...	—	—
5.	Number of visits made to schools		120
6.	Number of home visits		3

Analysis of children treated

		Boys	*Girls*
1.	Stammerers (Dysrhythmia)	13	3
2.	Defects of articulation due to:		
	(a) Cleft palate	4	—
	(b) Cerebral palsy	2	2
	(c) Other structural malformations	—	—
	(d) Other causes e.g. neurological	2	1
	(e) No specific cause found	94	34
3.	Disorders to language due to:		
	(a) Retarded language development (non-specific)	23	20
	(b) Retardation with associated subnormality	43	43
	(c) Retardation associated with deafness	—	—
	(d) Dysphasia	—	—
	(e) Aphasia	—	—
	(f) Other reasons	—	—
4.	Dysphonia	—	—
5.	Other defects	—	2

G. Other Treatment Given:

	Number of cases known to have been treated	
	1971	1970
(a) Pupils with minor ailments	553	537
(b) Pupils who received convalescent treatment under School Health Service arrangements	—	2
(c) Pupils who received B.C.G. vaccination	545	981
(d) Other than (a), (b) and (c) above—Ultra Violet Light ...	11	13
Total	1,109	1,533

Protection of School Children against Tuberculosis:

TUBERCULIN TESTING OF SCHOOL ENTRANTS:

The tuberculin testing of school entrants was introduced in order that in the case of a positive result it would lead to a search for a source of infection and at the same time secure the placing of the child under medical supervision in order to avoid the risks which follow primary infection.

The following shows details of the work undertaken under the provisions of this scheme:

Number invited	1,014
Refused	56
Absent	125
Previously examined	14
Negative	793
Positive	26

Of the 26 cases found to be positive, 15 had previously been vaccinated with B.C.G. and the remainder were referred to the consultant chest physician for further investigation and/or observation.

B.C.G. Vaccination of Older School Children:

The scheme for vaccination against tuberculosis of older school children was continued during the year, details of which are set out below:

Number of Medical Officers approved to undertake B.C.G. Vaccination	3
Number of children offered tuberculin testing and vaccination if necessary, whether the offer was made during the year or previously	878
Number found to have been vaccinated previously	90
Number of acceptances	585
Percentage of acceptances	74·24
Pre-vaccination Tuberculin Test—	
Number of children tested	579
Result of Heaf Test:	
(i) Positive 34, (ii) Negative 545 (iii) Not ascertained —	
Percentage positive	5·87
Vaccination—	
Number vaccinated	545

Included in the above figures are 49 immigrant children who were tuberculin tested as part of a full medical examination which was undertaken prior to their admission to school.

Ultra Violet Light:

Altogether 11 pupils received ultra violet light treatment of whom three were continuing at the end of the year. Through the inter-availability of clinics, two pre-school children also received ultra violet light treatment. A total of 81 sessions were held at which 222 attendances were made by pupils and 101 by the pre-school children.

Patients are normally referred by their general practitioners.

Care of the Handicapped Child:

Details of the number of handicapped pupils are given in the following table:

TABLE V

	New Ascert-ainments	Re-Ascert-ainments	New placings in Special Schools	Total No. attending Special Schools		Number awaiting placement in Special Schools	Number receiving home tuition
				Day	Boar-ding		
Blind	—	—	1	—	1	—	—
Partially Sighted	—	—	—	2	—	—	—
Deaf	1	—	—	3	2	1	—
Partially Deaf	—	—	1	2	2	—	—
Educationally Subnormal	9	13	15	64	2	9	—
Epileptic	1	—	1	—	1	—	—
Maladjusted	1	—	2	—	3	1	—
Physically Handicapped	1	—	3	9	2	1	—
Suffering from Speech Defect ...	—	—	—	—	—	—	—
Delicate	3	—	2	—	5	1	1
Total ...	16	13	25	80	18	13	1

BRAITHWAITE DAY SPECIAL SCHOOL:

At the end of the year 103 pupils were attending the Braithwaite Day Special School. Of these 64 were Keighley pupils, the remainder being admitted from areas situated outside the Borough.

Keighley pupils are admitted at an early age and only occasionally are pupils admitted who are more than seven years old.

MENTALLY HANDICAPPED CHILDREN:

No child was ascertained as being 'unsuitable for education in school' during the first three months of the year i.e. prior to the repeal on 1st April, 1971 of Section 57(4) of the *Education Act, 1944* as amended. The admissions which were effected to the Day Training Centre during this period all being on a voluntary basis; a practice which had obtained in Keighley for many years. Four children were admitted to Branshaw View Day Special School for severely subnormal pupils during the year. Eight children were recommended as being in need of placement in a special care unit. Two pupils were reported as requiring care and guidance on leaving school.

Nocturnal Enuresis:

During the year five pupils suffering from nocturnal enuresis were issued with an Eastleigh Warning Device on loan, of which two were still in use at the end of the year.

Health Education:

Series of talks were given in some schools, mostly to middle and primary schools by health visitors. The use of flannelgraphs, films, film strips and visual aids all added interest as did occasional observation visits to child welfare centres etc. Supplies of leaflets on child care and health subjects were in great demand from groups of school children who participated in school projects.

The health education topic on smoking and health was arranged to coincide with the national campaign on this subject. During this period leaflets and posters were displayed in schools. In an effort to discourage young children from starting to smoke, each year the parents of all eight year old children have been circularised and advised to ensure that their children were aware of the dangers involved in cigarette smoking and to do all in their power to dissuade them from starting the habit. Talks and films on the dangers of smoking were given during the health education programme which was undertaken in schools.

The annual home safety competition, organised by the Home Safety Committee for children from five years of age to school leavers, was once again a great success. The entries were of a high standard and the group efforts, which included posters and working models etc. made a colourful display at the prize giving which was held in the Technical College and later at the exhibition at Cliffe Castle. A good many schools visited Cliffe Castle in May when an excellent working model puppet show on home safety was on display for a week.

Dental Inspection and Treatment:

Mr. Midgley, Area Dental Officer reports:

It has unfortunately not been possible to effect an annual dental inspection of school children due to staff shortage. Although the number requiring treatment remains about the same, the amount of dental treatment each child requires has continued to be small, and thereby indicates that many parents arrange regular treatment for their children through the General Dental Service. As has been reported on several occasions, it is considered that the scientific evidence in support of the fluoridation of the public water supply is overwhelming and it is estimated that this procedure would reduce considerably the amount of dental decay in the population.

Table VI

Attendances and Treatment

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
First visit	530	844	199	1,573
Subsequent visits	373	2,020	467	2,860
Total visits	903	2,864	666	4,433
Additional courses of treatment commenced	46	70	20	136
Fillings in permanent teeth...	518	2,133	665	3,316
Fillings in deciduous teeth	107	7	—	114
Permanent teeth filled	518	2,133	665	3,316
Deciduous teeth filled	107	7	—	114
Permanent teeth extracted	105	481	93	679
Deciduous teeth extracted	898	311	—	1,209
General anæsthetics...	352	338	54	744
Emergencies	209	134	14	357

Number of pupils X-rayed	110
Prophylaxis	42
Teeth otherwise conserved	14
Number of teeth root filled	9
Inlays	7
Crowns	2
Courses of treatment completed... ...	1,493

Orthodontics

New cases commenced during year ...	63
Cases completed during year	58
Cases discontinued during year	13
Number of removable appliances fitted...	131
Number of fixed appliances fitted ...	3
Pupils referred to Hospital Consultant ...	—

Prosthetics

	Ages 5 to 9	Ages 10 to 14	Ages 15 and over	Total
Pupils supplied with F.U. or F.L. (first time)...	—	—	—	—
Pupils supplied with other dentures (first time)...	—	15	1	16
Number of dentures supplied	—	29	17	46

Anæsthetics General Anæsthetics administered by Dental Officers...	23

Inspections

(a)	First inspection at school. Number of pupils	4,335
(b)	First inspection at clinic. Number of pupils	855
	Number of (a) + (b) found to require treatment	2,393
	Number of (a) + (b) offered treatment	2,221
(c)	Pupils re-inspected at school or clinic	425
	Number of (c) found to require treatment	227

Sessions

Sessions devoted to treatment	435*
Sessions devoted to inspection	22
Sessions devoted to Dental Health Education ...	—

* Includes 2 anæsthetic sessions

APPENDIX D

STAFF OF THE HEALTH DEPARTMENT

as at 31st December, 1971

MEDICAL STAFF

County Medical Officer and Principal School Medical Officer	Ronald W. Elliott, C.B.E., M.D., M.SC., F.F.C.M., D.P.H.
Deputy County Medical Officer...	H. W. S. Francis, M.A., M.B., B.CHIR., F.F.C.M., D.P.H.
Principal Medical Officer: Care of Mothers and Young Children and Nursing Services	Denise E. Robertshaw, M.B., CH.B., M.F.C.M., D.P.H., D.C.H.
Liaison Service	D. E. Jeremiah, M.B., B.S., M.F.C.M., D.T.M. & H., D.P.H.
School Health Service	C. S. Smith, M.B., B.S., M.R.C.S., L.R.C.P., F.F.C.M.
Epidemiology	G. E. Leyshon, M.B., CH.B., M.F.C.M., D.OBST. R.C.O.G., D.P.H.,
Senior Medical Officer	J. A. Cooney, M.B., CH.B., B.A.O., D.T.M. & H.
Venereologist (part-time) ...	J. A. Burgess, M.D., CH.B., D.P.H.
Obstetrician (Joint appointment with Hospital Service)	J. C. MacWilliam, L.R.C.P., L.R.C.S., L.R.F.P.S., D.OBST. R.C.O.G.
Senior Medical Officers for the Child Guidance Service: ...	Katherine N. Maxwell, M.B., CH.B. R. V. Read, M.R.C.S., L.R.C.P., D.P.M. Hilary Sanderson, B.SC., M.B., CH.B., DIP. ED., D.P.H., D.P.M.

Divisional Medical Officers—

Division No. and Name	
1 (Skipton)	Vacancy
3 (Keighley)	V. P. McDonagh, M.B., CH.B., D.P.H.
4 (Shipley)	J. Battersby, M.B., CH.B., D.P.H.
5 (Horsforth)	A. Telford Burn, M.B., B.S., M.F.C.M., D.P.H.
7 (Harrogate)	N. V. Hepple, M.D., B.S., B.HY., D.P.H.
9 (Rothwell/Wetherby)	Elizabeth M. Hargreaves, M.B., B.S., M.F.C.M., D.P.H.
10 (Goole)	Muriel J. Lowe, M.B., B.S., M.R.C.S., L.R.C.P., M.F.C.M., D.P.H., D.C.H.
11 (Castleford/ Pontefract) ...	J. F. Fraser, M.B., B.S., M.F.C.M., D.P.H., D.OBST. R.C.O.G.
13 (Morley)	G. Ireland, B.SC., M.B., B.CH., M.F.C.M., D.P.H.
15 (Spenborough) ...	W. M. Douglas, M.B., CH.B., M.F.C.M., D.P.H.
18 (Calder Valley) ...	S. H. Brock, M.B., CH.B., M.F.C.M., D.P.H.

Divisional Medical Officers—continued

20 (Colne Valley) ...	J. P. Stuart, M.B., CH.B., M.F.C.M., D.P.H.
22 (Wortley)	F. C. Armstrong, M.B., CH.B., M.F.C.M., D.P.H.
23 (Hemsworth) ...	J. S. Walters, M.C., M.B., CH.B., M.F.C.M., D.P.H.
25 (Barnsley)	C. G. Oddy, M.B., CH.B., M.F.C.M., D.P.H.
26 (Wath upon Dearne)	D. J. Cusiter, M.B., CH.B., M.F.C.M., D.P.H., D.T.M. & H.
27 (Doncaster)	R. Stalker, M.B., CH.B., M.F.C.M., D.P.H.
29 (Thorne)	G. Higgins, B.SC., M.B., CH.B., D.P.H.
31 (Rotherham) ...	J. T. Clow, M.B., B.S., D.P.H.

Departmental Medical Officers and School Medical Officers—

Division No. and Name	
1 (Skipton)	*G. H. Cooper, M.B., CH.B. *Helen M. Dean, M.B., CH.B., D.P.H. *Shirley Jessop, M.B., CH.B., D.P.H.
3 (Keighley)	*J. I. Bennet, M.B., CH.B. *Doreen E. Gledhill, M.B., CH.B., M.F.C.M.
4 (Shipley)	*Adaline N. Ambler, M.B., CH.B.
5 (Horsforth)	*Helen M. Mitchell, M.B., CH.B., M.F.C.M. Agnes A. Crone, M.B., CH.B., D.C.H. Joan M. Murdoch, L.M.S.S.A. Annette M. Whalley, M.B., CH.B.
7 (Harrogate)	*Isobel B. Alexander, M.B., CH.B., M.F.C.M., D.P.H. *Gertrude M. Polson, B.SC., M.B., CH.B., M.F.C.M., D.OBST.R.C.O.G. Margaret Briggs, M.B., CH.B. A. W. I. Hall, M.B., B.CHIR.
9 (Rothwell/Wetherby)	*J. Briffa Boothman, M.D., D.P.H. Elizabeth M. Ingles, M.B., CH.B., D.P.H. Bevyl M. Stringer, M.B., B.S., M.R.C.S., L.R.C.P., D.OBST.R.C.O.G. Eileen A. Wain, M.B., CH.B., D.OBST.R.C.O.G.
10 (Goole)	*Eileen M. R. Bell-Syer, M.B., B.S. J. N. Lambton, M.B., CH.B.
11 (Castleford/ Pontefract) ...	Sheila F. Schofield, M.B., CH.B., D.P.H., D.C.H.
13 (Morley)	*Barbara Briggs, M.B., CH.B., M.F.C.M., D.P.H. Doreen M. M. Anderson, M.B., CH.B. Irene Hargreaves, M.B., CH.B. Ruth L. Skrine, M.B., CH.B.

Departmental Medical Officers and School Medical Officers—continued

15 (Spenborough) ...	*Freda M. Cox, M.R.C.S., L.R.C.P., D.P.H. Emma M. H. Holdsworth, M.B., CH.B. Alexandrina McPheat, M.B., CH.B., D.P.H. W. McPheat, L.R.C.P. & S., L.R.F.P. & S.
18 (Calder Valley) ...	*Marie P. Milligan, B.SC., M.B., CH.B., D.P.H. Sarla Chari, M.B., B.S. Rosemary J. Eccles, M.B., B.S. W. C. McKerr, M.B., CH.B., B.A.O.
20 (Colne Valley) ...	*L. Lloyd-Evans, M.B., CH.B. G. D. Roworth, M.B., CH.B.
22 (Wortley)	Melba R. McGinty, M.B., CH.B.
23 (Hemsworth) ...	*Josephine Hayes, M.B., CH.B. *C. H. Merry, M.R.C.S., L.R.C.P., M.F.C.M.
25 (Barnsley)	C. B. Ball, M.B.E., J.P., L.M.S.S.A.
26 (Wath upon Dearne)	*Margaret C. J. Bolsover, M.B., CH.B. *S. K. Pande, M.B., B.S., M.F.C.M., D.P.H. Elizabeth M. Harvey, M.R.C.S., L.R.C.P.
27 (Doncaster)	*J. A. Beal, M.R.C.S., L.R.C.P., D.P.H. Elizabeth R. M. Harvey, M.A., M.B., B.CHIR.
29 (Thorne)	Vacancy
31 (Rotherham) ...	Mary J. Daly, M.B., B.CH., B.A.O., DIP.L.M. Margaret M. Elliot, M.B., CH.B. Patricia J. Elson, M.B., B.S. Margaret J. Hallinan, M.R.C.S., L.R.C.P.

* Senior Departmental Medical Officers.

174 General Medical Practitioners who act as Child Welfare Centre Medical Officers and are employed on a sessional basis. This is the equivalent of 19·6 whole-time Departmental Medical Officers.

CHEST PHYSICIANS (Regional Hospital Board Appointments)—

LEEDS REGION

D. J. Charley, M.D., B.S., M.R.C.P., M.R.C.S.
G. F. Edwards, M.B.E., M.B., B.S., M.R.C.P., M.R.C.S.
H. Grunwald, M.D. (Vienna)
W. D. Hamilton, M.B., B.CH., B.A.O., D.P.H.
W. H. Helm, M.R.C.P., M.R.C.S.
J. W. Jordan, M.D., B.S., M.R.C.P., M.R.C.S.
M. J. Livera, M.D., B.S., M.R.C.P.
B. T. Mann, B.SC., M.D., CH.B., D.P.H.
J. K. Scott, M.B., CH.B., M.R.C.P., D.P.H.
D. K. Stevenson, M.B., CH.B., M.R.C.P.
J. Viner, M.B., CH.B.
J. Y. Walker, M.B., CH.B., D.P.H.
A. Weleminsky, M.D. (Prague)

SHEFFIELD REGION

D. H. Anderson, V.R.D., M.D., B.CH., B.A.O., D.P.H.
J. J. Danaher, M.B., B.CH., B.A.O.
F. C. N. Holden, M.D., B.S., M.R.C.S., M.R.C.P.
J. D. Stevens, M.D., B.SC., M.R.C.S., M.R.C.P.
R. H. Townshend, B.SC., M.B., F.R.C.P., M.R.C.S., D.T.M. & H.

Other Medical Specialists in the School Health Service (Regional Hospital Board and University Appointments)—

OPHTHALMIC

P. L. Bali, D.O.M.S., M.S., D.O.
S. K. Banerjee, M.B., B.S., D.O.
M. A. Davies, M.B., B.S., M.R.C.S., L.R.C.P., D.O.
S. B. Davies, L.R.C.P., L.R.C.S., D.O.
R. Hawe, M.B., CH.B., B.A.O., D.O.
M. Hussain, M.B., B.S.
M. A. C. Jones, M.B., CH.B., F.R.C.S., D.O.
B. A. Marshall, M.B., CH.B., D.O.M.S.
N. L. McNeil, M.B., B.S., M.R.C.S., L.R.C.P., D.O.M.S.
A. Pickering, B.S., M.B., CH.B., F.R.C.S., D.O.
K. K. Prasher, M.B., B.S., D.O.
T. B. Priestley, M.R.C.S., L.R.C.P., D.O.
S. Robertson, M.B., CH.B., D.O.M.S.
E. S. Tan, M.B., CH.B., D.O.M.S.

ORTHOPAEDIC

J. H. Annan, M.B., CH.B., F.R.C.S.
K. S. Davies, M.B., CH.B., F.R.C.S., L.R.C.P.
N. Grewal, O.B.E., F.R.C.S., M.CH.ORTH.
G. F. Hird, M.B., CH.B., F.R.C.S.
P. A. I. Macleod, B.SC., M.B., CH.B., F.R.F.P.S., F.R.A.C.S.
W. H. Maitland-Smith, M.B., CH.B., F.R.C.S., M.CH.ORTH.
J. K. Oyston, M.B., B.S., F.R.C.S.
M. A. Pearson, M.B., CH.B., F.R.C.S.
E. R. Price, M.B., B.S., F.R.C.S., M.R.C.P.

E.N.T.

P. J. Batchelor, M.B., B.S., F.R.C.S., D.L.O.
P. H. Beales, F.R.C.S.
T. B. Hutton, M.A., M.B., B.CHIR., F.R.C.S., L.R.C.P., D.L.O.
S. B. Mahatme, F.R.C.S.
K. M. Mayhall, M.A., M.B., B.CHIR., F.R.F.P.S., M.R.C.S., L.R.C.P., D.L.O.
H. Morus-Jones, M.C., M.B., B.S., F.R.C.S., L.R.C.P., D.L.O.
J. E. Rees, M.R.C.S., D.L.O.

PAEDIATRICS

P. C. N. Clarke, M.R.C.P., D.C.H.
C. S. Livingstone, M.R.C.P., D.C.H.
E. M. O'Neil, M.D., M.R.C.P., D.C.H.
J. D. Pickup, M.D., CH.B., D.C.H.
R. J. Pugh, M.B., CH.B., M.R.C.P., M.R.C.S., D.C.H.
G. Rajan, M.R.C.P.

CARDIAC

W. S. Suffern, M.D., CH.B., M.R.C.P., M.R.C.S.

PSYCHIATRIC

E. Gore, M.D., CH.B., D.OBST. R.C.O.G., D.P.M.
S. Hoyes, M.R.C.S., L.R.C.P., D.P.M., D.P.H.
J. D. Orme, M.R.C.S., L.R.C.P., D.P.M.

CHILD GUIDANCE SERVICE

Psychologists G. L. Ackroyd, B.SC.
P. W. Atkinson, B.A.
Felicity A. Brown, B.A.
Annette B. Castle, B.A.
D. Clark, B.A.
Joan Gillibrand, B.A.
Susan M. Goulding, B.SC., DIP. ED.
Jane E. Leach, B.A.
J. B. Mannix, M.ED.
P. J. Monaghan, B.A.
D. G. Pickles, M.A.
Rosalind I. Pilkington, B.A.
Julia C. Scott, B.A.
H. B. Valentine, M.A.

10 Psychiatric Social Workers (4 part-time).

SPEECH THERAPY SERVICE

Chief Speech Therapist ... Vacancy.
19 Speech Therapists (13 part-time).

DENTAL SERVICE

Chief Dental Officer and Principal School Dental Officer ... H. Taylor, L.D.S.

County Orthodontist G. A. Thompson, B.CH.D., L.D.S., DIP. ORTH. R.C.S., D.D.P.H.

Dental Specialist Joyce Neden, B.D.S., D.D.P.H.

Senior Clinical Dental Officers W. A. Allen, B.D.S., L.D.S.
F. H. Sanderson, L.D.S

Area Dental Officers ...	...	J. R. Clayton, B.CH.D., L.D.S., D.D.P.H. K. R. Cowell, B.CH.D., L.D.S. E. Doherty, B.D.S. P. F. A. Eltome, L.D.S. J. D. Franks, L.D.S. Mary M. Gibson, L.D.S., R.F.P.S. Valerie P. Lindsay, L.D.S. E. Lowery, B.D.S. A. S. Metcalfe, L.D.S. E. S. Midgley, L.D.S. S. Mitchinson, L.D.S. J. Naftalin, L.D.S., R.F.P.S. M. S. Ormesher, B.D.S. B. Sleight, B.CH.D. H. G. Thorpe, L.D.S. H. M. Yuile, L.D.S., R.F.P.S.
Senior Dental Officers..	...	A. W. Glenn, B.CH.D. M. Merrick, B.CH.D.
School Dental Officers	...	Susan C. Antrum, B.CH.D. A. Brooke, B.CH.D., L.D.S. Mary G. Brown, B.CH.D. Shirley C. Clapham, B.CH.D. Eileen M. Cooper, B.D.S. M. Davidson, B.D.S. Joan M. Davison, L.D.S. W. H. Dyke, L.D.S. Jean G. Elliott, L.D.S. Lesley M. M. Fitzharris, B.D.S. D. K. Goodwin, B.D.S. R. F. Grainger, B.CH.D., L.D.S. J. R. Grant, B.D.S. M. Hattan, L.D.S. Hazel M. Hill, B.D.S. Gurdeep Kaur, B.D.S. (Bombay) F. Kershaw, L.D.S. J. M. Laurent, B.D.S., D.D.P.H. R. B. Lawrence, L.D.S. M. J. Limb, B.D.S. C. F. Martin, B.CH.D., L.D.S. P. R. Oldfield, B.D.S. M. J. Prendergast, B.D.S. Jessie Rothera, L.D.S. R. L. Selby, B.D.S. D. J. Sinnett, B.D.S.

School Dental Officers (continued)

W. J. Smalley, B.CH.D.
P. Smith, L.D.S.
M. Stamp, B.D.S.
A. G. Tetlow, B.D.S.
E. Thornton, L.D.S.

4 Dental Auxiliaries

Chief Dental Technician ... K. A. Battersby

8 Technicians

3 Boy Dental Apprentices

64 Dental Surgery Assistants

NURSING AND MIDWIFERY

Chief Nursing Officer Marjorie G. Atkinson, D.N., S.R.N., S.C.M., H.V.CERT., D.T. (Queen's)

Principal Nursing Officers ... Irene Endean, S.R.N., H.V.CERT., N.D.N.CERT.
Naomi I. Harris, S.R.N., S.C.M., H.V.CERT., D.T. (Queen's)

Non-Medical Supervisors of Midwives Margaret J. Astin, S.R.N., S.C.M., M.T.D.
Agnes Sellars, S.R.N., S.C.M., H.V.CERT., M.T.D.

16 Divisional Nursing Officers
21 Senior Health Visitors/School Nurses, (First Line Managers)
287 Health Visitors/School Nurses (23 part-time)
131 Assistant Health Visitors (65 part-time)
6 Physiotherapists (5 part-time)
1 Tuberculosis Visitor
4 Venereal Diseases Social Workers (Qualified Health Visitors)
18 Senior Home Nurses and Home Nurse/Midwives, (First Line Managers)
346 Home Nurses and Home Nurse/Midwives (37 part-time)
7 Senior Midwives (First Line Managers)
162 Midwives (13 part-time)

AMBULANCE SERVICE

County Ambulance Officer L. Lord, F.I.A.O., M.R.S.H., A.M.B.I.M.

Deputy County Ambulance Officer J. C. Gledhill, A.I.A.O., D.P.A.

2 Assistant Ambulance Officers

1 Training Officer

Operations Staff:

Headquarters 56

Field 663

PUBLIC HEALTH INSPECTORS

Chief County Public Health Inspector ... D. Greenwood, M.A.P.H.I.
County Public Health Inspectors... ... J. D. Clayton, A.R.S.H., M.A.P.H.I.
D. Jagger, M.A.P.H.I.

2 Pupil Public Health Inspectors
2 Technical Assistants

HEALTH EDUCATION

Principal Nursing Officer ... Mary Tattersall, D.N., S.R.N., S.C.M., H.V.CERT., D.T. (Queen's)

2 Health Education Technicians

ANALYSTS

County Analyst R. Mallinder, B.SC., F.R.I.C. (part-time).
Deputy County Analyst N. Harrison, M.CHEM.A., A.R.I.C. (part-time)

ADMINISTRATIVE AND CLERICAL

Chief Administrative Officer G. Richardson, D.P.A.

Sectional Administrative Officers ... J. H. Milne, D.P.A.
H. Beatson
W. J. Battye
R. S. Marshall
T. Myton, D.P.A.
T. R. Schofield, D.P.A., L.H.A.
J. W. Ibbotson
C. J. Kirk, A.M.B.I.M.

Administrative Officers E. Brown
H. V. Brook
D. Marshall, D.P.A., L.H.A.
D. Ramsbottom
P. Ward, D.P.A.
G. Brabant

19 Divisional Administrative Officers

351 Other Clerical Staff (including part-time)